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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and due to the cause and due to the cause of the cause	To Be Completed by Physiclan/Medical Examiner	21. Signature Pundal Service Robert H. 23a. Part1. Enter the disease shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying. Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 Yes 2 No 9 Unknown Part II. Dther significant contains a cause of the cause o	Braces, Braces	b. Due to (Due	aused the deal ach line. (or as a consection of pregnant at time of cown eath but not research time of cown inpatient 2 Inpatient 2 of Injury th, Day Year)	quence of):	Town Ceme 22 Name and Addr Bradsnaw 306 W. Ma. enter the mode of dy Cother (specify) Town Ceme 22 Name and Addr 306 W. Ma. 306 W. Ma. 10 Other (specify) 11 Indian Ind	tery 4/1 ass of Facility ass o	23e. Did to 24a. Was a autops perfor 1 Yes 28d. Describe ho 28f. Location (S.	Mode me ielo rest, bacco u fes 2 [an sy med? 2 [con injury fence con injury fireet and	23d. Date of de Month Se contribute to No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Spe	Approximate Interval Betwee Onset and Dea

State Registrar

APR 1 5 2005 DHMH 17 Rev 1/2001

0. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Steven Hamlette, M.D. 100 (arrol) Streat Salisbury Md

31. Date filed (Month, Day, Year)

32. Registrar's Signature docates

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23a Part Enter the disease of complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest. Approximate shock or heart failure. List only one cause on each line. Pre-Lumonia Pre-lum	<u>.</u>	Pag ment ant: I ury o		'4 □ Donation 5 □ Other (Spe	cify)	st.	. Stani	islaus Ce			Balt:	imore, M	aryland
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					105	Registrar's Sign	nature	ride				,	

				1- State of Maryland / Department of Health and Certificate of Death		ene g. No.	15	13003
				Decedent's Name (First, Middle, Last)	2. Date of Death	1		3. Time of Death
		Physici /Medio		JOSEPH NICKOLAS PRINDEZE	April 1	3, 2005	/ear	6:57 P M
		Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec	ath	4c. County of	Death	
				Greater Baltimore Medical Center Towson		Balt	imor	e
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H 1 1 2 1		Year)	9. Birthpl Count	ace (State or Foreign
		Director		220-18-7982 A 76	Jul 20,	1926	Mary	land
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
		Mary -1 she	ठ्	Maryland Baltimore County Timonium				1 ☐ Yes 2 ☑ No
		r 28a	Director	Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code	10	g. Citizen of Wh	nat Count	ry?
2		death with the Maryland ms 23a or 28a-f show rmust be notified at	OF	2120 Suburban Greens Drive 21093		IIG	۸	
S.		deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race	America White, e	
8	98	or Ita	F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No WWII 1 □ Yes 3 □ No Specific	sito i ilidani, oto.)	Specify:		
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Q.	7	n 72 • nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wife. DO NOT use retired)	rorking 1	6b. Kind of Busi	iness/Ind	ustry
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=	Maryland	should by should be should	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I				
CI		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23s or 28s-f show any figury or other traumatic avant, Ira Madical Examiner must be notified at ance.		Betty A. Prindeze (Wife) 2129 Suburban Greens	Danies Md		M	21.002
	Baltimore,	of He fitan		20a. Method of Disposition 1 ➡ Burial 2 □ Cremation 3 □ Removal from State Note that the property of the place of Disposition (Name of Cemetery, Crematory or other place)	But Ac , 11	on Straighte	ity To	A, Slate 3
	Ĕ	Pag ment ant: I ury o		`4 Donation 5 □ Other (Specify) Dulaney Valley M.Grdhs 4	/18/05 I	imonium	, Ma	ryland
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		<u></u>		Martin D. Lawson 6500 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	Baltimore.	. nome, - Marvla	nd 2	1 21 2 Approximate
_				shock, or heart failure. List only one cause on each line.	ac or respiratory arre	st, "1042 y 12ci		Appföxlmate Interval Between Onset and Death
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		signed d be del	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		_		cause of death?
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	Division of Vital Records,	rsician: The law s certificate has t lirector, page 2 s	Be	examiner?	eath (Check only one			
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	ă	al or s after l Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town,	State)		
		To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and plants.)	ce, and due to the cau	use(s) and mann	ner as sta	ted.
		the H in 24 the Fi	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocan and manner stated.	curred at the time, dat	e and place, an	a due to	tne cause(s)
		To T Com	Σ	29b. Signature and title of certifier 29c. License number		d. Date signed (Month, D	Pay, Year)
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		100		30. Name Ind address of person who completed cause of death (Item 23a) (Type, Print)	S I SUCCESSION	42.	UKSS	Constant of the Hill
				31. Date filed (Month, Day, Year) 32. Figistrar's Signature	# HOO.)	Tow50	(LIN	A) 313(A)
		Sta Registr		31. Date filed (Month, Day, Year) A PR 1 5 2005				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 9, Jean Prass Phillips 2005 7:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Oak Crest Village Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2X F Yrs Director 185-12-1250 Feb. 17, 1922 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8830 Walther Blvd. 21234 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Be Completed by 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill f Health and Mental H fam 27 ia marked oth Mathias (unk) Prass Anna (unk) Potter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Ruth A. Phillips / Daughter 11 Clearlake Ct., Parkville, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State = 0 permit. Page Department of Important: If any injury or once. * 4 □ Donation /5 ☑ Other (Specify) Hilltop Service Corp. 4-12-05 Towson, Maryland 21. Signature of the aral pervise Licensee Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician vasco lar Cerebral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimasis 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 HO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending

within 24 hours after death.

To the Funaral Director: After thi
completely filled in by the funeral To the Hospital

Certification; To investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NO monic 1)5864

State Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boulevard

Parkvilla

		,	State of Registrar	Maryland / D	epartment of F	lealth and M		ne2005	13005
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month <	Day Year	3. Time of Death
	/Media Examin	cal	Richard Roy Powell 4a. Facility Name (If not institution, give street and numb Genesis Perring Pork 5. Social Security Number 6. Sex 7.	Age (In yrs. last birth	Parkuy If Under 1 Year	r Location of Death	8. Date of Birth	4c. County of Death Balton	II OO A M
	Director		213-36-4230	66 Y	rs. Months Days	Hours Min.	(Month, Day, Yea	1938 Mary	
	he Maryla 18a-f shov offfired at	ector	MD Baltimore		ville		10		1 ☐ Yes 2 🙀 No
	s 23a or 3	Funeral Director	10e. Street and Number 7710 Hillsway Ave.	ant Fives in U.S.	10f. Zip Code 21234		US	T	
9036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28a-f show aumatic event, the Medical Examinar must be mutified at	by Fune	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Date	₹ ^{No}	13. Was Decedent of Hif Yes, specify Cub	Specify: whit		14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	within 72 hand and then "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of workir d)	ng	Kind of Business/In	ŕ
land 2	ld be filed ental Hygie kad other ic event, III	To Be Co	17. Father's Name (First, Middle, Last) Edgar Roy Powe11	Truc	k Driver	18. Mother's Name	(First, Middle, Maid	ransporta en Sumame)	tion
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Marcal Examinat must be notified at once.	ř	19a. Informant's Name/Relationship (Type, Print) Frances E. Martinez – Dau; 20a. Method of Disposition	ghter 771	Mailing Address (Street O Hillsway	and Number or Rura Ave. Park	Route Number, Cit ville, Ma		.234
Baltimore,	permit. Pages Department of h Important: If ite any injury or of		1 ■ Burial 2 □ Cremation 3 □ Removal from St. 4 □ Donatture of Funeral Service Licenses	216	Disposition (Name of crematory or other plane) Park Cemeto 22. Name and Addre	1	11, 05 Ba	ltimore c	ity
	9 E E B		23a. 1-11. Enter the disease, or comincations that cau	sed the death. Do no	3620 Wilke	ens Ave. B	altimore,		Approximate Interval Between
	Physician /Medical Examiner	iner	Sequentially list conditions b.	Prenumoi as a consequence of as a consequence of	f):				Onset and Death
68760,	ficate be executed g physician and ts the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or d	as a consequence of	f):				
P.O. Box	Physician: The law requires that the death certifical this certificate has been signed by the attending phraid director, page 2 should be detached for use as it	Physician/Med		h 2 Fetal death it at time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	4		23d. Date of deliv Month	ery Day Year
	v requires that been signed should be de	by	Part II. Other significant conditions contributing to dear	h but not resulting in	the underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to t 2 ☐ No 3 ☐ Prot	7,53
of Vital Records,	i: The law ricate has be	Completed					24a. Was an autopsy performed 1 Yes 2 1	prior to co death?	ppsy findings available impletion of cause of
of Vita	Physician: Th r this certificate rral director, pag	To Be	25. Was case referred to medical examiner? 1 To Hospital: 1 Inp. 27. Manner of Coath 28a. Date of	Injury 28b. Tir		4 Niersing Hon	(Check only one) ne 5 □ Residence 8d. Describe how in		(y)
Division	To the Hospitel or Attending Physician: The law requir within 24 hours after death. To the Funerel Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Certification:	1 Destural 5 Pending (Month, 2 Accident investigation 3 Suicide 6 Could not be determined determined	Day Year) Inj	jury Woi	rk? Yes 2 □ No	8f. Location (Street City or Town, St	and Number or Rura	al Route Number,
J	e Hospitei 124 hours Funerei letely filled	edical Ce	29a. Certifier (Check only one) (Check only one) (Check only one)	is of examination and/	death occurred at the til /or investigation, in my o	me, date and place, a pinion, death occurre	nd due to the cause ad at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
	To th within To th comp	Me	29b. Signature and liftle of certifier		29c. Licens			Date signed (Month,	
_	9		30. Name and address of person the complete cause Natili Fritishing mo Goods	of death (Item 23a) (T	Type, Print) Syptal Prof.	Bulding #	303 Bello	we has 2	1239
	Sta Registi		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	hartis	3			

DHMH 17 Rev 1/2001

ORIGINAL

Box 68760, →
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Records,
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			State of Man						. 10000
			RegistraAmend Item 6 per fh G84 1. Decedent's Name (First, Middle, Last)	12 Cei	rtificate of	Death 4–1	8-05 tas		3. Time of Death
	Physici /Medic		FRANK	PETILLO			APRIL	Day Yea 12 200	1 - 20 20
)	Examin	ıer	4a. Facility Name (If not institution, give street and number)	ALTIMORE	, ,	r Location of Deat		4c. County of De	
	Funeral		5. Social Security Number 6. Sex 7. Age (/	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8 Date of Birt	h a P	Sirthplace (State or Foreign
	Director		214-40-3613 Was Residence of Decedent	79 Yrs.	Months Days	Hours Min.	(Month, Day 03-18-	1926	ITALY
	Maryland a-f show ified at	tor)—————————————————————————————————————	Oc. City, Town or Lo		ERVILLE			10d. Inside City Limits 1 ☐ Yes XX No
	h with the	al Director	10e. Street and Number 1541 PICKETT ROAD		10f. Zip Code	21093		10g. Citizen of What I	•
0000	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. did blygiene. dother than "natural", or flems 23a or 28a-f show dither than "natural", or flems 23a or 28a-f show event. It e Madical Examiner must be natified at	by Funeral	11. Marital Status 1 Never Married XX Married 1 Never Married XX Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XX No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, WI Specify:	nerican Indian, nite, etc. WHITE
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/land	should be filed id Mental Hygii marked other matic event, II	To Be (17. Father's Name (First, Middle, Last) EDWARDO PETILLO)			ne <i>(Fir</i> st, <i>Middl</i> e, SIGIIA	Maiden Sumame) ALFANO	
Man	nd 2 sh lith and 27 is rr r traum		19a. Informant's Name/Relationship (Type, Print) C. MARTA PETILLO (WIFE)	19b. Mailir 1541	-			r, City or Town, State LE, MARYLA	
<u>5</u>	Pages 1 ar nent of Hea int: If item iry or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo	matory or other plac	ce)	Date	20c. Location - City	
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0	Depar Impor any ir		P. H. Rus		UCK TOWSO	,	L HOME,I	NC. TOWSO	YORK ROAD N,MD.21204
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	S767N	A DEF	HTT			Approximate Interval Between Onset and Death Own
	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the con	onsequence of):	RE BRUV	145aa	AC A	CCIDENT	12 849
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time past 12 months? 4 ☐ Pregnant at time per per per per per per per per per pe	Fetal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of d Month	elivery Day Year
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Mal	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or	-	es 2 No
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DIVISION	To the Hospital or Attending Physimiting A hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (3	- At home, farm, str Specify)			28f. Location (S City or Tow	treet and Number or i m, State)	Rural Route Number,
	Hospita 24 hours Funeral stely filled	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of many and manner stated and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, o	ause(s) and manner a date and place, and de	as stated. ue to the cause(s)
	within To the compli	Me	29b. Signature and title of certifier	-	29c. Licens	e number	2	29d. Date signed (Moi	nth, Day, Year)
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			1 - State Registrar C6	partment of Health and Mental Hygertificate of Death	giene eg. No. 2005 300
>	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) Marguerite Virginia Rosenberry 4a. Facility Name (If not institution, give street and number) 2551 Southdene Avenue	2. Date of Dea Month April 4b. City, Town, or Location of Death Baltimore	th Day Year 13 2005 3:05 P M 4c. County of Death n/a
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 T 80 Yrs.		9. Birthplace (State or Foreign
	Maryland B-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Maryland n/a Baltim		10d. Inside City Limits 12QVes 2 ☐ No
	with the	I Direc	10e. Street and Number 2551 Southdene Avenue	10f. Zip Code 21230	Og. Citizen of What Country? United States
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mentat Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-1 show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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	and 2 sho ealth and n 27 Is ma			ling Address (Street and Number or Rural Route Number Harman Avenue, Baltimore,	
Baltimore,	be mit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr		I Durial 2 Dicremation 3 Dremoval from State	position (Name of Pate synatory or other place) Crematory 4/18/2005	20c. Location · City or Town, State Baltimore, Maryland
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	diac Ischemia	est, Approximate Interval Between Onset and Death
760,	be executed ician and burial-transit	cal Examiner		rtery Disease	may years
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f Vital		To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check only on ont 3 DOA Other: 4 Nursing Home 5 XReside	
ion of	<u>F</u> = <u>F</u>		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		ow injury occurred
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28I. Location (SI City or Town	reet and Number or Rural Route Number, , State)
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	To the within To the complex	Me	29b. Signature and title of cartifier Cuettra Rayauis		9d. Date signed (Month, Day, Year) April 13 / 2005
か	\		30. Name and address of person who completed cause of death (Item 23a) (Type GETHA RHJA IND) 4367 HOLINS		, MD-21227
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 5 2005 32. Jegistrar's Signature		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2005 **Physician** Ŏ9 Edward С. Rockwell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1028 Cedar Ridge Court Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day Jan. 30 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1958 1⊠M 2□F 47 Yrs 217-58-1467 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location in than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 XNo Directo Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1028 Cedar Ridge Court 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Stack, White, etc. filed within 72 hours after Hygiene. other than "natural", or ita 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Wine Consultant Wine & Spirits other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Cecilia Kesecker Rockwell С. Aburn Joe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Water Pointe Lane, Reston, VA 20194 Leslie Rockwell (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) April Date 14 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Baltimore, Maryland 21. Signature Funeral Service Cons Stallings Funeral Home, P.A. 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) **Physician** Kena month tallure /Medical Due to (or as a **Examiner** 1ac Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Vital 1 ☐ Yes 2 ☐ No 2 100 To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After Certification: 28d. Describe how injury occurred Division 1 Naturat 5 Pending death. M 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours e To the Funaral [29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-36885 30. Name and add ess of person and completed cause of death (Item 23a) (Type, Print) Stephen 500H GOTHIED 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State Registrar

			1 - State of M	laryland / Department of Health and M Certificate of Death	lental Hygiene
	Physici /Medio		1. Decedent's Name (First, Middle, Last) EDWARD	RYTEL	2. Date of Death Month Day Year APRIL 2005 13 1 74
}	Examin	ier	4a. Facility Name (If not institution, give street and number 5. Social Security Number 6. Sex 7. A	4b. City, Town, or Location of Death A V I W BALTI MOP ge (In yrs. last birthday) TO Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director Mou		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	3-9-24 MAK YLAND
	vith the Ma or 28e-f s	Director	10e. Street and Number	DACT MORE 101. Zip Code	1 ☐ Yes 2 No 10g. Citizen of What Country?
36	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to Health and Mental Hygiene. If itsm 27 is marked other then "neturel", or Items 23e or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Armed Forces	!? If Yes, specify Cuban, Mexican, Puerto f	Acify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: // hite
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_	Pages 1 and 2 s nent of Health ar int: If itsm 27 is iry or other treu		Mary Grace Rytel 20a. Method of Disposition 1 Disposition 3 Removal from State	20b. Place of Disposition (Name) of Disposit	Pate 20c. Location - City or Town, State
Baltimore,	permit. Pag Department Importent: eny injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lidensee	Holy Kosary Conceeny 14-14	MORE, MD 21234. APE 8800 HARFORD RD.
	rnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ad the death. Do not enter the mode of dying, such as cardiac or the second of the sec	
8760, 8	be executed ician and purial-transit	cal Examiner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ZENAL FAILURE	18 LLITUS 10 YEARS
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	To the Hospite within 24 hours To the Funerel completely filled	Medical	29a. Certifier (Check only one) Check only one) Check only 1 □ Medical Examiner: On the basis and manner s	t of my knowledge, death occurred at the time, date and place, a of examination and/or investigation, in my opinion, death occurre tated. 29c. License number	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
)	- VI		Mond A. An		
K	3011	to	30. Name and dress of person who completed cause of CHASA LCOM 31. Date filed (Month, Day, Year) 32. Regis	MD 5505 HOPKINS BAY. trar's Signature	VIEW CIPCLE BARTIMENE, MD 21224
	Sta Registr		APR 1 5 2005	a de frede	21004

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State of Maryland / Department of Health and Mental Hygiene

		1- State of Maryland / Department Certification	nt of Health and Mental te of Death	Hygien	2005 100	110
Physicia /Medic		Decedent's Name (First, Middle, Last) MARY NICKALENA ROSS	2. Date Mon APR	of Death th Da TL 1	3. Time of 3. Time of 9:30	f Death OAM M
Examin		4a. Facility Name (If not institution, give street and number) 4b. City MANOR CARE ~ ROSSVILLE	, Town, or Location of Death ROSSVILLE		c. County of Death BALTIMORE	
Funeral Director			or 1 Year If Under 24 Hrs. 8. Date Days Hours Min. Sept	of Birth th, Day, Year,	9. Birthplace (State of Country) 920 Maryland	
aryland show	,	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore Baltimore			10d. Inside Ci	ity Limits
or 28a-f	Directo	10e. Street and Number 10f. Zi	p Code	10g. C	itizen of What Country?	54.A.110
NOTE, MARYIANG 21213-UU36 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-1 show or other treumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	21237 seent of Hispanic Origin? (Specify Yes cify Cuban, Mexican, Puerto Rican, et	or No-	USA 14. Race - American Indian, Black, White, etc. Specify: White	
Z1Z15-UU36 d within 72 hours all gione. er than "naturel; or	pieted by	15. Decedent's Education 16a. Decedent's Usu	ual Occupation ork done during most of working	16b. h	Specify: White Kind of Business/Industry	
ba filed with tal Hygiene. d other than event, the M	Be Com	9th grade N/A Homemak 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, A	Aiddle, Maidei	emaking-Own Hor n Sumame)	me
Maryland 1d 2 should ba file 1th and Mental Hy 27 Is marked oth 1reumatic event	Tof		Lucia Puglis s (Street and Number or Rural Route n Court Kingsville	Number, City		
Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 1s in eny injury or other treum once.		20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) XX Donation 5 Other (Specify)	me of Date	20c. L	ocation - City or Town, State timore Maryland	d
Dalti. permit. Departm Importe eny inju		21. Signature of Funeral Service Licensee 22. Name a 7401	Belair Rd. Baltim	ore. Ma	ral Home aryland 21236	
Fnysician /Medical	8 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	de of dying, such as cardiac or respira	tory arrest,	Approximate Interval Bate Onset and I	ween
BOX 08/00, and certificate be axecuted attending physician and for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):				
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_ > 0 0	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 Deliver of Death 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) M				
To the Hospital or Attending Ph within 24 hours attending Ph To the Funeral Diractor: After thi completely filled in by the funeral:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factor building, etc. (Specify)	y, office 28f. Loca City	tion (Street ar or Town, State	nd Number or Rural Route Numi e)	ber,
To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred at the	time, date an	d place, and due to the cause(s))
To To	•	1 Club	D44604	29d. Da	ate signed (Month, Day, Year)	
Ve		30. Name and address of person who of Malalest takes of Jeans (Type Print) The Harry Color (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	THORE M	0	26234	
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4-13-05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** James G. Ralls, Sr. 6:32 A M April 12, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8036 Gray Haven Road Dundalk Baltimore Co. 8. Date of Birth (Month, Day, Year) Dec. 8,1920 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Director 229-16-9844 Virginia Usuat Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-1 show The Modical Examiner must be notified at 1 ☐ Yes 2 No Directo Mary1and Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8036 Gray Haven Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

**X*Yes 2 | No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes ŽXNo Specify: Specify: 9 3 Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic perceived. Steel Industry Police Officer 7 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be D. Wright James Η. Ralls Hattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara T. Ralls (Wife) 8036 Gray Haven Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 4/14/2005 Dorsey, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Buda-Ruck Funeral Home of Dundalk, Inc.

Buda-Ruck Funeral Home of Dundalk, 21222 22. Name and Address of Facility 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Examiner To the Hospital or Attanding Physiclan: The law requires that the death certificate be executed USPLE the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1/ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical le of certifier 29b. Signature and to 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add who completed caus 8

Registrar DHMH 17 Rev 1/2001

State

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			1 - For State Registrar	State of Maryland		ment of Health icate of Deatl		ntal Hygie	4000	13012
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	with the	i Direc	10e. Street and Number 3/5 INGLES	1		0f. Zip Code 21228		10g.	Citizen of What Cou	intry?
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Balt	permit. Pag Department Important: I any injury o		21. Signature of Foneral Service Licens	Hack y	22. Na	ARDAF.H	ility 282	9 HUD	SON 57.	24
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	ne Hospital n 24 hours a ne Funeral (edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death occion and/or investi	curred at the time, date a gation, in my opinion, de	and place, and eath occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		Ň	29b. Signature and title of certifier	Hallie	à	29c. License numbe	35	29d.	Date signed (Month	, Day, Year) -
	3		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, Print	APR HEI	Orti	1 6	BAET	m) 2/208
6	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure Locale	į.	- 1 -			

	1.	State of Maryland / Department of Health an Certificate of Death	•		005	13013
	1.	Decedent's Name (First, Middle, Last)	2. Date of D Month	eath Day	Year	3. Time of Death
Physician /Medical		ALICE REITZ	April	14.	2005	9:27 A M
Examiner	4a	Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of City.			unty of Death	
		Mariner of Catonsville Catonsville		В	altimor	e
Funeral	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Bi Min. (Month, D			lace (State or Foreign try)
Director		220-07-4343 1 M 2 K 96 Yrs. Months Days Hours	JAN. 19	190	9 Mary	
D		sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location		-		Od. Inside City Limits
show		MD Baltimore Halethorpe			'	1 ☐ Yes 2√2 No
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23a or 2	10			-		uy?
ms 23a	-	63 Colony Hill Court 21227 I. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	2 (Specify Ves or N		USA Race - Americ	an Indian
Sifter death virtems 23e	111	Armed Forces? If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	J- 14.	Black, White,	
D36		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Sp	ecify: whi	te
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altimor nit. Pages artment of ortent: If it injury or o		'4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 4	/15/2005	Bel	tsville	MD
Baltimore, semit. Pages 1 a Department of Hes mportent: If item nry injury or othe 2006.	2	Signature of Funeral Service Licensee 22. Name and Address of Facility				
w 39 E 2 8		Gary L. Kaufman I 7250 Washington I	Blvd. Elk	me @ Me	MD 2	1075
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ysicien: Th ysicien: Th is certificate director, pag		examiner?	Death (Check only	one)		
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the Hospi in 24 hour the Funer pletely fill	2	9a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and p (Check only only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death only only	place, and due to the occurred at the time,	date and pla	d manner as st ace, and due to	ated. the cause(s)
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b		O. Name and address of person who completed cause of leath (Ifem 23a) (Type, Print) Workelium D. Abverne by 5/6 N. Ro (luc M	Bul	Ky ha	11228
State Registrar	3.	1. Date filed (Month, Day, Year) APR 1 5 2005 32 Registrar's Signature	0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #2&20b PER FH Sphy 9842 4/15/05 Reg. No. 2. Date of Death APR. 6, 2005 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 0233M SCOTT WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hosptial Columbia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**XM 2□ F 64 Director 04 VA 230**-**56-4255 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Columbia Howard MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21045 U.S.A. 5465 Hound Hill Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes ANO Specify: Specify: Black ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Assistant Balto City Schools 2yrs 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ella Mae Scott Zander Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Heelth and Important: if Item 27 is rr any injury or other traum once. 5465 Hound Hill Court, Columbia, Md 21045 Juanita Scott-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/13/2005 1 Burial 2 Kremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Metro Crematory Inc. 21. Sonatur of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or *comp*lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final disease or condition resulting in death) SEPSI. Physician /Medical Due to (or as a consequence of); 24 HRS Examiner MIHOMNSH Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transIt Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMV+ 1 Probably 4 Unknown peen s 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No 1 Yes 2 No spital or Attending Physician: Thous after death.
uneral Director: After this certificat if filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manney Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Division 1 unatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Hospital 29a. Certifier 1 🖸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MY 018457 MAR 08, 2005 u nues 30. Name and address of person who completed call-e of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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	Funeral Director		5. Social Security Number 551-38-7063 Usual Residence of Decedent	□ F / · Age	75	Yrs.	Months Days		Min. (Month, Da	y, Year)	1929 C	
	aryland show	_	10a. State 10b. County		10c. City, T						1	Od. Inside City Limits
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036	within 72 hours after death with the Maryland one. than "neturel" or Items 23e or 28e-f show the Modical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 T	s Decedent E ned Forces? Yes 2 ☐ No es, Give ar or Dates:			Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2 🛱 No	spanic Origin n, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Americ Black, White, Specify: Wh	
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Mar	and 2 shou salth and M n 27 Is mar ier treumati		19a. Informant's Name/Relationship (Type, Print VAMC	nt)			-		or Rural Route Number			•
ore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova.	from State	20b. Place ceme	of Dispo etery, crer	sition (Name of natory or other place	Ī	Date		cation - City or To	
	permit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligens	11 1	L-MD V		ans Cem . Name and Addres		′15/05 Stallins		ownsville	
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)	Vithi Som	M	29b. Signature and title of certifier August C. 30. Name and address of person who complete	Tan	Au cath (Item 23	D,	D 14			29d. Date	signed (Month, I	Day, Year)
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 April 9, **Physician** 7:30pm M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Greater Baltimore Medical, Center Baltimore Towson 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex. **Funeral** 1**1** M 2□F Months Days Hours 215-24-1332 Usual Residence of Decedent Director 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examples must be notified at once. 10a. State 1 ☐ Yes 2 ▼ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 W No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 Married 1 Never Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4015+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RMON 19b. Mailin Jodress (Street and Number or Rural Roy te Number, City or Town, State, Zip Code)

19b. Mailin Jodress (Street and Number or Rural Roy te Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Warial 2 Cremation 3 Removal from State . 4 □ Donation 5 □ Substitute 1. Signatore of Funeral Service Licenses 22. Name and Address of Facility Vaugba C Greene Funeral Strk. Kandallstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pinbuble Renal pilmury **Physician** Metastatic Cancinona 3 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown Misticille Divihec 1 ☐ Yes 2 ☐ No Metastatic Mostate 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2X No Carcinona autopsy performe To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Appatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

29b. Signature and title of certifier

Bonne Colm MS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sullmore MJ 32. Registrar's Signature

A Car Jo

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

4/10/05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Pate of Death Decedent's Name (First, Middle, Month .40AM Physician 2005 am nomas /Medical 4c. County of Death 4a Facility Name (It actinistitution, give street and number) Extended Baltimore Kenabilitation and Extended Care Center 4b. City, Town, or Location of Death Examiner altimor N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1**X** M 2 □ F Yrs. Director 03-15-1917 88 216-16-8599 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No TURNER STATION BALTIMORE MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 132 CHESTNUT STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify:BLACK WWII þ 3X Widowed 4 □ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL LABORER other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be MAGGIE TAYLOR treumetic WILLIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Depirtment of Health ar Importent: If Item 27 is any injury or other treu QDGs. 132 CHESTNUT STREET, BALTIMORE, MD 21222 LEONA SMITH/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) LAUREL, MD 4-21-2005 MD NATIONAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALT., MD 21217 23a. Part v Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) rostate Pnysician cancel rear /Medical ue to or as a consequence **Examiner** rena hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine burial-transit e DTIC u attending physician and Due to for as a consequence of): Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 2 No 1 Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 XiNursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending

or Attending Physicien: The law requires that the death certificate be executed filled in by the funeral director, Director: After Division death. after within 24 hours a

1 Natural
2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

Medical 29b. Signature and title of certifier

(Check only one)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. License number 29d. Date signed (Month, Day, Year)

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	Physi this c	1º	1 ☐ Yes 2 🗙	10		ent 2 EF		No. of the last terms	4 Nuising n	ome 5			city)	_
Division of	ding f h. After funer	ertiflcation;	27. Mann of Dilati	5 Pending	28a. Date of Inju (Month, Da	y Year)	8b. Time of Injury	28c. Injun Wor	yat k? Yes 2 □ No	28d. Describe	now injury	occurred		
S	or Attendi after death. Director: A in by the fu	lcat	2 Accident 3 Suicide	investigation 6 Could not be	-	urv - At hom	e farm str	eet, factory, office	163 2 1100	28f. Location	(Street and	Number or Ru	ral Route Number,	-
<u>≤</u>	or / Oire in b	erti	4 🗌 Homicide	determined	building, et	c. (Specify)	-,,	out, increasy, office			own, State)			
	e Hospital or 24 hours afte e Funeral Dis etely filled in	alc	29a. Certifier		ysician: To the best									_
	To the Hospital within 24 hours a To the Funeral is completely filled	edical	(Check only one)	2 Medical Exam	iner: On the basis of and manner sta	f examinatio ated.	n and/or inv	estigation, in my o	pinion, death occu	rred at the time	, date and p	place, and due	to the cause(s)	
	To t To t	Σ	29b. Signature and	title of certifier -	> 1	10		29c. Licens		3.6	29d. Date	signed (Mgnt)	n, Day, Year)	
	^		1	7					4139	· - 1	7	11 2/4	7	
	18		30 Name and address	A Styles	completed cause of a	eath (Item 2	(Type,	Print) Blvd	St 72	4. Bel	1 MC	7/	224	
	Sta Registr		31. Date filed (Mont	th, Day, Year)	completed cause of completed cause of completed cause of completed cause of complete cause of completed cause of	ar's Signate	A POP	whi.						Ī

			1 - State Amend Item 23	State of Marylan e per phy G84	d / Depa 2 4 20 - Cen	rtment of H -05 tas tificate of I	ealth and f Death	Mental Hygie	ne Na no c	10010
	• •	J.	Decedent's Name (First, Middle, Last)	^				2. Date of Death		3. Time of Death
	Physici		Tomas	Arribas	Ja	nZ		Month	Day Year 12.2005	7:32P M
	/Medic Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death	1	4c. County of Death	E B but herr C
塘			Saint Joseph	Medical Cen	ter		Tows	on	Balt	imore
	Funeral Director		ala-18-1698	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) O Cqui	place (State or Foreign htry).
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				Od. Inside City Limits
	Manyl f sho	5	MD RAITIM			wtherr	:110			1 ☐ Yes 2 No
	28a-	rect	10e. Street and Number	Ore		10f. Zip Code	1110	10g.	Citizen of What Cou	ntry?
	3s or	Ī	1308 Warwic	k iv					min	
	death	Funerai Director		12. Was Decedent Ever in U. Armed Forces?		/as Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race - Americ	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiens. Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event. It e Medical Event errount be insufficed at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	o Rican, etc.)	Black, White,	otc.
5-0	72 hours "natural", Jical Ere	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decede	ent's Usual Occupa	ation furing most of wor	kina 16b	. Kind of Business/In	dustry
2121	within ena than "	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)		1	-
2	filed with Hygiena. Ithar thai		17. Father's Name (First, Middle, Last)		Heac	d Chet	10. Mathada Nas	To de la constante de la const	estauro	un!
Maryland	should be filed within Mantal Hygiena. marked other then metic event, ILE M	Be	17. Famer's Name (First, Middle, Last)	0007			O 1	ne (First, Middle, Maid	den Sumame)	
Ž	should nd Man marka umatic	ပ	19a. Informant's Name/Relationship (Ty)	na Print)	10h Mailine	Address (Street	LOJALI	ral Route Number, Ci	VOCAS	Codel
Ma	d 2 sho th and th and traum		CO COLO DO POR O 7	= 1) 6	130.14	- 11	ING NUMBER OF THE	C L	ty or rown, State, zip	2 1402
a)	s 1 and 2 of Health item 27 l		20a. Method of Disposition	20b. F	Place of Dispos	ition (Name of	lick to	Date 20c	Location - City or To	own, State
Baltimore,	⊕ ○ = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		atory or other place	9)	d 05		
Ħ			21. Signature of Funeral Service License		NS FUNE	Name and Addres	s of Facility	1-03	ORESTH	
B	permit. Departr Imports any inju		Kim ber 1.11	Zo Jeal L.	OF	2	325 YOU	ULRO. TIM	PASO P	DZIOTS
		9	23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death	h. Do not ente				icito-()E)	Approximate
	Physician	8 8	Immediate Cause (Final			2250				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	SSECT. uence of):	LUN				9_HOURS
10	Examiner	1	Conventially list conditions							
0.0		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
Ġ.	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
90,	e be axecuted sician and burial-transit		leading in death, cast	Due to (or as a consequence	uence of):					
8760,	the the	dicai								
9 xo		U 1	IF FEMALE:	3c. If yes, outcome of pregna	IDCV					
Bo	death certif e attending od for use as	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
0	0 0 0	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	out 5 🗔	Othor (specify)				
<u>α</u>	The law requires that the ate has been signed by the page 2 should be detache	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause give	n in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
rds	n sign							Yes	2 No 3 Prob	ably 4 Unknown
Records,	s been s should	Completed						24a. Was an	24b. Were auto	psy findings available
Re	The lav	mo						autopsy performed	? death?	mpletion of cause of
Vital		a	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	No 1	76140
>	ys di	0 B	examiner?	ospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe		ome 5 Residence	6 □Other (Specif	y)
J of		T:uc	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how in		
Division	ittandir death. ctor: Af / the ful	Certification:	2 Accident investigation		,		res 2 □ No			
<u>≅</u>	ter de iracto	Ħ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (Street City or Town, St	and Number or Rura tate)	l Route Number,
	ital c									
	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Medicai	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the cause rred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of dertifier	1		29c. License	number	29d.	Date signed (Month,	Day, Year)
)			4	M.V.		ומ מ	257593	710	111,13	1005
	1		30. Name and addréss of person who co	mpleted cause of death (Item	1 23a) (Type, P			- 1		
	(OF EXPRINED OF NO	M. D 76121	nsi FP	DRIVE	TOWSON -	MARYLAND	212274	
	Sta Registr		31 Oad mild Mild Daly, vol NA APR 115 20	M 52 ngistrar s signa	to do	ale	s had to the had to the	· · · · · · · · · · · · · · · · · · ·	tame at tame tame \$6.00	

			1 - For State Registrar	State of Ma	ryland / Depa	artment of F		, ,	ene g. N2. 0 0 5	13020
			1. Decedent's Name (First, Middle	, Last)				2. Date of Death	1	3. Time of Death
	Physici /Medi			George	Α.	Schmitt		Month April 1	Day Year 10, 2005	9:12 P M
>	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
			7200 Kimmel A	Avenue		Dund	la1k		Balt	imore Co.
	Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birn	thplace (State or Foreign
	Director		216-20-5578	1□XM 2□ F	78 Yrs.			June 11	,1926 Ma	aryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryl sho	ō		altimore			Dundalk			1 Yes 2 No
	28e-	ect	Maryland E	arcinore		10f. Zip Code	Darraga	10	g. Citizen of What Co	
	with le or	Ö	7200 Kimmel	Avenue			21222		-	
	ours after death with the Marylan reft, or Items 23e or 28e-f show Examitter mat be mattified at	Funeral Director	11. Marital Status	12. Was Decedent E	iver in U.S. 13.	Was Decedent of H	lispanic Origin? (Spr		United Sta	
"	r Iten	Fun	1 Never Married 2 Marrie	Armed Forces?	0		lispanic Origin? (Spo an, Mexican, Puerto	Rican, etc.)	Black, Whit	
036	urs a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes XX No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland 'naturel', or Items 23e or 28e-f show digal Exaciliser, well be invilled at	Completed	15. Decedent' (Specify only highest	s Education	16a. Dece	dent's Usual Occup	ation during most of work	ina 1	6b. Kind of Business	
21	o u	nple	Elementary/Secondary (0-12)	College (1-4or 5-	/ife.	DO NOT use retired	during most of work	ing		_
21	filed within Hygiene. other than "	Cor	4 Years		B	rakeman			Rail Road	d
E E	be d o	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Name			
Yle	2 should be and Mental is marked o	၉	Frank Schmitt					ret Getz		
Maryland	s 1 and 2 should if Health and Men item 27 is marke other treumetic		19a. Informant's Name/Relationsh						City or Town, State, 2	
ď.	1 and Health tem 27		Mr. Charles R. 20a. Method of Disposition	SCHWITT (201	20b. Place of Dispo					
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		1 ⊠ Burial 2 ☐ Cremation		cemetery, crer	matory`or other plac	(a)	-11	Oc. Location - City or	
Ξ	t. Pa rtmer rtent	1	4 Donation 5 Other (Sp				sus ¢em. 4	1/13/2005	Dundal	k, Maryland
Bal	permi Depa Impo any ir		21. In a nature of Funeral Service to	icensee /	/() Di	2. Name and Addre: uda-Ruck	Funeral H	ome of D	undalk, I	nc.
			23a. Part . Enter the disease, or o	- Caul	70	222 Wise	Ave. Dun	dalk, Ma	ryland 21	222
			snock, or neart failure. List of	inty one cause on each line	9.		10		st,	Approximate Interval Between Onset, and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a Heut	myoca	ardial	intar	chon		Mour
	Examiner		, , , , , , , , , , , , , , , , , , , ,	Due to (or as a	consequence on:					1 15
		-	Cequentially list conditions,	Due to a a	consequence of:	iran				10 years
	ted nsit	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		00,100 quality 0.7.					~
	al-tra	ха	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	lcal [
.89	ificate g phy as the	edlc		u.						
Вох	death certifica attending ph I for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deli	iverv
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year
O.	that the de led by the detached	hys	9 🗆 Unknown	9□ Unknown						
٥,	es tha igned be del	by P	Part II. Other significant condition	s contributing to death but	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	icco use contribute to	the cause of death?
ğ	w requires been sign should be	eted I						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Records,	s t	plet						24a. Was an	24b. Were au	topsy findings available
č	0 - 9	dmo						autopsy performe	prior to death? No 1 □ Yes	completion of cause of 2 \sum No
ita	icien: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death			20110
of <	Si ib	70 6	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Hor	ne 5 Aesiden	ce 6 □Other (Spec	cify)
			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work	at 2	28d. Describe how		
Ö	Attending r death. sctor: After by the fune	atic	2 Accident investiga	ation	,		Yes 2 □ No			
Division	I or Attendater death Director: I in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		y - At home, farm, stre (Specify)	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	itel o									
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	Check only 2 Medical E	Physician: To the best of xaminer: On the basis of e	examination and/or inv	occurred at the time	ne, date and place, a	and due to the cau	ise(s) and manner as	stated.
	the thin 2 the mplet	Med	0118)	and manner state	ed.					
	Z M		29b. Signature and title of certifier	10-102-	na i	29c. License	4560	290	d. Date signed (Month	1, Day, Year)
,			7.2.	nosium	フルレ	01	6960	1	+pill 11	4005
10	HT		30. Name and address of person w	ho completed cause of de	ath (Item 23a) (Type, I	Print)	PLA	Rollin	in ml	21222
U			31. Date filed (Month, Day, Year)	32 Rodictor	's Signature	TEYPIII 4	7/10/	y I FIM	016/11/0	1005 , 21222
	Sta Registr	-	APR 1	5 2005	K A	Carles				İ
			HTH I	O COOL KEEL	40 10 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 128 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rice MORE TOUSE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 1**X**M 2□F Hours 56 Yrs. Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Medical Examiner rust be notified at 17 1 Yes 2 □ No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a Funeral 12. Was Decedent Ever in Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Completed by DAITE 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired); 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fit h and Mental F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trains timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Gremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 1224 23a. Part1. Enter the disease, complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dving, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** months disease or condition /Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy , page certificate 2∐ No 1 🗆 Yes director 25. Was case referred to medical 26. Place of Death (Check only one, examiner? 1≥ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours at Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 805 ww

State Registrar 31. Date filed (Month, Day, Year) 32

APR 1 5 2005

30. Name an address of person who com

leted cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M	aryland / D	Depar <i>Certi</i>	tment of H <i>ificate of L</i>	ealth D <i>eath</i>	and M		iene () ()	5 3022
	Physici		1. Decedent's Name (First, Middle, Last	•						2. Date of Deat Month		3. Time of Death
	/Medic		,		Stadler					April	14 20	205 2:00/1 M
7	Examin	er	4a. Facility Name (If not institution, give Union Memorial Ho			4	4b. City, Town, or Baltir				4c. County of N/A	
	Funeral Director		213-12-7097	7. Ag	ge (In yrs. last birt 82		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, January	Year)	Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loca	ation					10d. Inside City Limits
	Maryi f sho jed a	ō	Maryland N/A		Balt	imor	e City					1 X Yes 2 ☐ No
	7.28a	Director	10e. Street and Number		1		10f. Zip Code			1	0g. Citizen of Wha	at Country?
	h with		5724 Onnen Road				21206	5			U.S.	Α.
	ems	Funerai	11, Marital Status	12. Was Decedent Armed Forces?		13. Wa	as Decedent of Hi res, specify Cuba	spanic Oi	rigin? (Spe	city Yes or No- Rican, etc.)		American Indian, White, etc.
36	or It	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give	No	100]Yes 2∏No	Specify		, ,	Specify:	White
21215-0036	hour stural	ed b	15. Decedent's Edu	Year or Dates:	16a	Deceder	nt's Usual Occupa	ation			16b. Kind of Busin	ness/Industry
215	nn 72 n ne Medic	plet	(Specify only highest grad Elementary/Secondary (0-12)			(Give kir life. DC	nd of work done of NOT use retired	during mos	st of worki	ng	TOD. TAILS OF BUSIN	iess/maustry
212	giene giene er the	Completed	12 yr's	College (1-401)	5+)	Hom	ne Maker				Own Hom	ne
b	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23s or 28s-f show event, the Medical Exerth at Frast be notilized at	Be	17. Father's Name (First, Middle, Last)	٠						(First, Middle, A	Maiden Sumame)	
<u>Y</u> a	ould I Men Parke	2	Edward	Stei					lary		Fousc	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then. "natural", or Items 23a or 28a-f show amy injury or other treumetic event, Item Medical Exactlant mast be nutilised at once.		19a. Informant's Name/Relationship (T) Mr. Francis A. St								City or Town, Sta	ate, Zip Code) 21206
<u>ရ</u>	1 an Heall tem 2		20a. Method of Disposition	10161 - 11			ion (Name of tory or other place				20c. Location - Cit	
ē	Pages ent of nt: If i		1 Burial 2 Cremation 3 ☐F 4 ☐Donation 5 ☐ Other (Specify)				tory or other place of Faith		4/20		Baltimo	
Baltimore,	mit. F Dartm. Dorter / injur		21. Signatur of uneral Service License) dar de						Maryland	
m	Pag E a		+ tout I. W	utola	12	Lec	onard J.	Rucl	k. In	c. 530!	5 Harfor	d Rd.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that cause ne cause on each i	d the death. Do n							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Holah			oma					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	7						
1	LXMIIIII	er	Sequentially list conditions,	b. Our to for an	a consequence o	T.						
	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- Dua to (or as	a sensequence e	и).						
,	execun n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence o	of):						
8760	icate be executed physician and s the burial-transit	dicail		d								
စ		Medi	IF FEMALE:	-2								
Вох	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ctopic pregnancy				23d. Date o Month	f delivery Dav Year
o.	it the death certific by the attending partiached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant a 9□ Unknown	t time of death	5 🗆 O	Other (specify)				WORLT	Day 1 da
<u>a</u>	The law requires that the death certifite has been signed by the attending to age 2 should be detached for use as		Part II. Other significant conditions co	ntributing to death t	out not resulting in	the unde	eriving cause give	n in Part	J.	23e. Did tob	acco use contribu	te to the cause of death?
Records,	uires tha signed Id be del	d by					, , , , , , ,			1 □ Ye	s 2 No 3	Probably 4 Unknown
Õ	w require been sli should b	Completed								24a. Was ar	n 24b. Wer	e autopsy findings available
Re	The lav	ошр								autopsy	y prio	re autopsy findings available r to completion of cause of th?
Vital		BeC	25. Was case referred to medical					26. Place	e of Death	(Check only one		THES ZEE NO
>	nysici nis ce direc	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatie	ent 2 ER/Out	tpatient	3□ DOA Othe	r: 4 □ Ni	ursing Hon	ne 5 🗆 Resider	nce 6 Other (Specify)
Division of	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		ime of njury	28c. Injury Work	?		8d. Describe ho	w injury occurred	
<u>S</u>	tendi death. for: A the fi	Certification;	2 Accident investigation 3 Suicide 6 Could not be	00 81 11				′es 2 🗌		0() (0)		
\leq	or Attendater death	ertif	4 Homicide determined	building, et	jury - At home, far ic. <i>(Specify)</i>	m, street	t, factory, office		2	City or Town		or Rural Route Number,
	To the Hospitel or Attending Physicien: white 24 hours after deals. To the Funerel Director: After this certifica completely filled in by the funeral director, to		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge	, death o	ccurred at the tim	e, date ar	nd place a	nd due to the ca	use(s) and manne	er as stated
	e Ho	edicai	(Check only 2 Medical Exami	ner: On the basis o and manner st	i examination and	dor inves	stigation, in my op	inion, dea	ath occurre	d at the time, da	ite and place, and	due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number		29	d. Date signed (A	fonth, Day, Year)
			· Ellit Ste	ne De)—		110061	180)		April 14.	2005
_	9		30. Name and address of person who co	ompleted cause of c	death (Item 23a) (Type, Pri	int)			0	e, Many	. 0
1	1		Elhot Share Pac	201	East C	imp	ersity 1	arhu	vay	Balhmor	e, Many	land 21218
	Sta Registr		31. Date filed (Month) (Par Year) 5 2	UUD 32. Jogisti	ar's Signature	No sold						

ROY SADLER 05-02602 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Marylar		tificate of l			Reg. No.?	13023
Physici /Medic		1. Decedent's Name (First, Middle, Last) Roy Luther Sadler					2. Date of De Month APRIL	13, 2005	
Examin		4a. Fecility Name (If not institution, give s 5503 EDNA AVE	street and number)		4b. City, Town, or BALTIMO		ath	4c. County of De	ath
uneral rector		170-07-9540	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		9. B er 4, 1919 Per	irthplace (State or Foreig Country) INSY I Vania
show ed at	or	Usuel Residence of Decedent 10a. State 10b. County Maryland N/A		ty, Town or Lo 1timore	cation				10d. Inside City Limit
a or 28a-	Direct	10e. Street and Number 5503 Edna Avenue			10f. Zip Code 21214	·-		10g. Citizen of What (Country?
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multised at once.	by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 Yes 2 X No	ispanic Origin? In, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - An Black, Wh	
r than "natura the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L Cabin	dent's Usual Occupi kind of work done o DO NOT use retired NET Maker	ation during most of w)	vorking	16b. Kind of Busines Carpentry	s/Industry
rked other tic event,	ro Be C	17. Father's Name (First, Middle, Last) Murray Sadler				18. Mother's N Maria Li		, Maiden Sumame)	
127 is ma er trauma		19a. Informant's Name/Relationship (Ty Walter Sadler/Son	рө, Print)		ng Address <i>(Street a</i> 1enmor e Av e		Ru <i>ral R</i> oute Numb timore Mary	er, City or Town, State, land 21206	Zip Code)
nt: If Item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. lemoval from State	Place of Dispo cemetery, cren 1top Ser	sition (Name of natory or other plac vice Corp.	e) 4/15	Date 5/05	20c. Location - City of Towson Mary	
Importa any inju once.	1	21. Signature of Funeral Service License	2 11	ilton 7	Name and July echand J. 1	of Facility UCK Inc.	altimore Ma	ryland 21214	100
physician and in a color street in a color stree	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		shot w quence of):	oormds(2) t				Interval Batween Onset and Death
been signed by the attending physicia should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)	344	7	23d. Date of d Month	elivery Day Year
n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		tobacco use contribute Yes 2 ÅNo 3 □ F	to the cause of death? Probably 4Unknow
SO	Completed						24a. Was auto perfo	psy prior to prmed? prior to death?	autopsy findings availab completion of cause of as 2 \sum No
this certific at director,	To Be	IA 165 2 NO	Hospital: 1 ☐ Inpatient 2 ☐			er: 4 🗆 Nursing		dence 6 XOther (Sp	pecify) SCENE
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Sucide 6 Could not be	28a. Date of Injury (Month, Day Year) 4-13-5	28b. Time of Injury	word S M 1□	/at <br Yes 2 ⊠ΩNo	subject	how injury occurred Shot hiv	1
To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At he building, etc. (Special Section 1) building, etc. (Special Section 1) building and the best of my kn	(h) A+	home	a date and pla	Baltir	wn, State) 5503	Edna Ave
he Fun pletely	Medical		ner: On the basis of examination and manner stated.			pinion, death oc			ue to the cause(s)
o E			7		00	CME			
Tot		30. Name and address of person who co		m 93a\ /T:		51112		APRIL 14,20	005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day **Physician** David Benton Smelser, Sr. April 6:30 A 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2012 Falls Grove Wav Fallston Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 75 Yrs 220-20-8795 Director July 19, 1929 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits traumatic avant, the Medical Examiner must be nutified at Maryland Harford Fallston Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21047 2012 Falls Grove Way USA Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status □Yes 2☑No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Car Man Mechanic Railroad Pages 1 and 2 should be filed v nent of Health and Mental Hygie ant: If itam 27 is marked othar I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Nolan Smelser, Sr. Millicent Lane Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret B. Smelser/Wife 2012 Falls Grove Way, Fallston, MD 21047 rtment of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö Cedar Hill Cem. 4-14-2005 Baltimore, MD pernit.
Dep. rtm
Importa
any nju 21. Signature of uneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009
enter the mode of dying, such as cardiac or respiratory arrest,

Application 23a. Part1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardia Immediate Cause (Final Physician Ope Hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronary S usnimy standard if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To tha Hospitel or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown in signed by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 ģ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 sesidence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a

To the Funaral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 033642 Avenue Belthr 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

				1 - For State Registrar	State of		id / Depa		t of H	ealth and Monath	lental Hyg	_	05	13025
		Physici	an	1. Decedent's Name (First, Middle, La		CLIMICK					2. Date of Dea	ith	Year	3. Time of Death
		/Medic Examin	al	MARY ELIZ 4a. Facility Name (If not institution, given Gilchrist Cent	ve street and nur	SCHMICK			Town, or	Location of Death	April	13, 20 4c. Coun	JU5 ty of Death Balt:	
		Funeral Director		215-48-6452	Sex 1 M 2 TF	7. Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day February	, Year)	9. Birth	place (State or Foreign ntry) / land
		yland tow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
		Ba-fsh	ector	Maryland Baltimo	re	To	owson							1 ☐ Yes 2 (1)(1)(0)
		3a or 2	Dire	10e. Street and Number 1055 West Joppa	Road			10f. Zip	212	204		I0g. Citizen of		ntry?
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, If a Medical Evariginal must be nutified at once.	y Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Fo 1 Tes If Yes, Giv	2 ∕(□ X No ′e		Was Decedi f Yes, spec		spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ice - Ameri ack, White,	
	2-00	72 hour natural	ted b	3(X)Widowed 4 Divorced	Year or Da	ates:	16a. Deced	dent's Usua	I Occupa	ition		16b. Kind of I		
	Maryland 21215-0036	within 7	Completed by	(Specify only highest gr Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L			uring most of worki	ng	O		
	2 br	e filed of Hygie other i	Be Co	17. Father's Name (First, Middle, Last				HOME	emake	18. Mother's Name		Maiden Surna	Home	2
	ylar	ould build build light l	To E	Emil Novak							beth Ro			
	Mar	of 2 shall the and all the and		19a. Informant's Name/Relationship John E Schmick	(Type, Print)	Son	1			nd Number or Rura Place Lu				
	Baltimore,	es 1 al of Hea if itam ir othe		20a. Method of Disposition XX Burial 2 □ Cremation 3	Removal from	20b. F	Place of Dispo-	sition (Nam	e of her place	p) C	ate	20c. Location	- City or To	own, State
	ij	it. Pag intment intant: I njury o		'4 □ Donation 5 □ Other (Special Service Lice	fy)	Dru								Maryland
	Ba	Depar Depar Impo	1	Dennis Steps	en lo	rakes		Name and	Addies	s of Facility Mit 6500 York				
4	No.	Pnysician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on e	aused the deat ach line.			of dying					Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
		7 = =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of):							
	3760,	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):							
	ງີ ອີກ O. Box 68	0 0 D	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 Feta ant at time of d	I death 3	Ectopic pre Other (spe			,,,,		ate of delive	ery Day Year
Elizaten	of [2]	requires that the deen signed by the	by	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I.	23e. Did to			he cause of death?
	Rec	aw is b	Completed								24a. Was a autops perform	v	Were auto prior to co death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
many	Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Y} \) No	Hospital:	npatient 2	EB/Outnotion	3000	Othe	26. Place of Death		-		Jasaiaa
4.	of	ding h. After fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Mont	npatient 2 L of Injury th, Day Year)	28b. Time of Injury		Bc. Injury Work	4 Nursing Hor	ne 5 ☐ Reside 28d. Describe ho			Mapice
Schmick	Division	afte Dir	Certification:	3 Suicide 6 Could not be determined	286. Place	of Injury - At hong, etc. (Specif	ome, farm, stre	eet, factory,	office	2	28f. Location (Si City or Town		b e r or Rura	d Route Number,
0,		To the Hospital or A within 24 hours after To tha Funaral Dire completely filled in b	Aedical	(Check only 2 Medical Exa	miner: On the ba	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	restigation,	in my op	e, date and place, a inion, death occurre	ed at the time, d	ate and place	and due to	the cause(s)
		To the within To the comple	W	29b. Signature and fittle of certifier	lou	O		29c.	D S	8303 Les St V	P	9d. Date signe	13 2	OC)
	1	7		30. Name and address of person who	completed caus	e of death (Iten	60/ /	V C	ras	Les St 1.	Baltin	M MI	24	204
	•	Sta Registr		31. Date filed (Month, Day, Year) 5	2005 32.5	oistrar's Signa	itures A	7346	,					/

			1 - For State Registrar	State of Ma	arylan	•	artment of H	lealth a	nd Mental Hy	•	
			Registrar 1. Decedent's Name (First, Middle, L	actl		Ce	rtificate of	Death	2. Date of De	Reg. No. CUUD	13026
	Physici	an	ESTHER	asi)			SCHWARTZ		Month	11, Day 2005	3. Time of Death 5:15 A M
>	/Medic Examin		4a. Facility Name (If not institution, gi	ive street and number)			4b. City, Town, o	or Location of		4c. County of Dea	
	LXdiiii		NORTH OAKS HEAL				PIKESVIL		Alle	BALTIMORE	
1	Funeral Director		213-01-7409	Sex 7. Ag	e (In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bir Min. JUNE 1	1,1918 9. Bin	thplace (State or Foreign buntry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examiliating the multied at	ctor	MD BAL	TIMORE		BALT	IMORE				1 Yes 2 No
	with th	Funeral Director	10e. Street and Number				10f. Zip Code	0100		10g. Citizen of What Co	
	eath v	eral	725 MT. WILSON	LANE 12. Was Decedent	Ever in U	S 13	Was Decedent of H	2120		14. Race - Ame	USA
9	after d	Fun	1 X Never Married 2 Married	Armed Forces?					in? (Specify Yes or No Puerto Rican, etc.)		e, etc.
003	ural, o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE
15-	in 72 ł	oiete	15. Decedent's l (Specify only highest g	rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	of working	16b. Kind of Business	/Industry
21215-0036	d within giene. er than "	Completed	Elementary/Secondary (0-12)	5+ College (1-4or 5	5+)	TEAC		_,		EDUCATION	
pu	ld be filed within 72 hours afte ental Hygiene. ked other than "natural", or I ic event, I'e Medical Exertil	Be	17. Father's Name (First, Middle, Las	st)		20111			's Name (First, Middle	Maiden Sumame)	E400E0
Maryland	should ind Men ind marke imarke	ဥ	MOSES 19a. Informant's Name/Relationship	(Type Print)		SCHW		MAR and Number		er, City or Town, State, 2	FARBER Zin Code)
	nd 2 allth a 27 is r tra		GLENN SCHWARTZ				NORWOOD			E, MD 21218	ip codey
Baltimore,	00		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐Removal from State	20b. P	lace of Dispo emetery, crea	osition (Name of matory or other plac	ce)	Date	20c. Location - City or	Town, State
tim	Pa ner ant ury		`4 ☐ Donation 5 ☐ Other (Spec	eify)	HEBI				4/14/2005	WOODLAWN	
Ba	permit. Departr Imports any inj		21. Signature of Funeral Service Lice	attle						SON & BROS. PIKESVILLE,	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused y one cause on each lie	the death	. Do not ent	er the mode of dyir	ng, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SUPRA		LLAR	ME	NINC	MOMA		Onset and Death
н	Examiner			Due to (or as	a consequ	uence of):					
	D =	ner	Sacuentially list conditions if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):			-		
	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a concedu	ience of\-					
8760,	rate be executed thysician and the burial-transit	icai E		500 to (or us	2 0013041	2011.04 01/.					
9	tificate ng phy as the	ed		U							
Вох	death certifica e attending ph d for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3[Ectopic pregnancy	/		23d. Date of del	ivery Day Year
P.O.	at the de by the a tached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡Unknown	time of de	eath 5	Other (specify) _			17.3.13	24,
	law requires Ihat the as been signed by th 2 should be detache	by Pr	PaixII. Other significant conditions	contributing to death b	ut not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ord	w require been sig should b	ted	DEMENTA						1	res 2□No 3□Pr	obably 4 Dunknown
Records,	0 - 0	Completed							24a. Was autop		topsy findings available completion of cause of
Vital		0	25. Was case referred to medical			· · · · · · · · · · · · · · · · · · ·		26 Place	1 ☐ Yes	2₽No 1□Yes	2 2 No
of <	ys dis	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatie		ER/Outpatier	nt 3□ DOA Oth	er /		dence 6 Other (Spe	city)
	ling Ph n. After th funeral		27. Manuel of Death . □ Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry y Yea <i>r</i>)	28b. Time of Injury	Wor			now injury occurred	
Division	Attending r death. ector: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of Inju	ury - At ho	me, farm, str	M 1 (Yes 2□N	28f. Location (Street and Number or Ru	ıral Route Number,
á	tal or safter al Dire	Certification;	4 Homicide	building, et	c. (Specify	′)			City or Tou	vn, State)	
	To the Hospital or Attending Pwithin 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical	29a. Certifier Check only one) Certifying P	hysician: To the best miner: On the basis of and manner sta	f examinat	wledge, deatl ion and/or in	n occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1			29c. Licens	e number		29d. Date signed (Monti	h, Day, Year)
	(Jasuem)	Yallh	au		2	2859	5-	4/11/05	
_	10	,	30 Name and address of person who IASNEEM LAK	completed cause of d	eath (Item	23a) (Týpe,	Print) HE	Contro	AVE, A	DALPOMD.	21208
	Sta R egistr		31. Date filed (Month, Day, Year) APR 1 5 200	HANI 7.	ar's Signa	ture south	(i)				

				State of Maryland / Dep. Oa, 23a per Dr. FH, C8		Mental Hygi	ene
			Registrar 1. Decedent's Name (First, Middle, Las		timoate of Beath	2. Date of Death	The state of the s
	Physici		Ernest McNile	<u> </u>		Month	Day Year
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dec	111	4c. County of Death
	Exami	iei	man .	of BAITIMORE	BAITIMORE Ci		N/A
	Funeral		5. Social Security Number 6. Se		*	8. Date of Birth (Month, Day,	
	Director		Usual Residence of Decedent	7.3		11-1-19	931 Virginia
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show evant, the Madical Examiner must be notified at		10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
	should be filed within 72 hours after death with the Marylan nd Mental Hygjene, marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show marked other than Medical Examiner must be rediffied at	to	M gar MD N/A	Bal	timore		XX Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	11 wi		4204 Newbern A	venue	21215	Į	JSA
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or It	by F.	1 Never Married 2 Married	1 Yes 2 No7 - 24 - 52	1 ☐ Yes 🛠 ☐ No Specify:	,	Specify: Black
ö	ural'		3 Widowed 4 Divorced	Year or Dates: 7-8-54			
7	"nat	Completed	15. Decedent's Ed (Specify only highest grad	de completed) 16a. Dece	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	6b. Kind of Business/Industry
2	withi ene. than	E G	Elementary/Secondary (0-12)	COII000 (1-40r 5+)	Driver	F `	ellow Cab Independent)
0	filed Hygid other ant,	ပိ	11th grade 17. Father's Name (First, Middle, Last)			ame (First, Middle, M	
an		o Be	Admiral McNile	Sydnor		ie Wormle	
Maryland 21215-0036	and Men is marke	2	19a. Informant's Name/Relationship (T		ng Address (Street and Number or I		
	Ith an 27 is		Marva Loretta S				more, Md 21215
Baltimore,	ges 1 ar t of Hea if Itam or other		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place) 4/	1 Page 05 2	Oc. Location - City or Town, State
e E	permit. Pages Department of H Important: If Its any injury or of		1 □ Donation 5 □ Other (Specify		Forest Vet.		wings Mills,Md
<u>=</u>	ortan inju		21. Signature of Funeral Service Lyns				arris Funeral Home
m	Per		Veres Her	5			altimore, Md 21215
			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lications that caused the death. Do not en	ter the mode of dying, such as cardi	ac or respiratory arre	st, Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	0			Onset and Death
1	/Medical		resulting in death)	a Due to (or as a consequence of):	2		
П	Examiner		O company of the line of the l	Long Standing	Hypertension		
		ner	if any, leading to immediate	Due to (or as a consequence of):			
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter uncerlying Cause (Disease or injury that initiated events	C			
,09/	e be executed /sician and e buriat-transit		resulting in death) Last	Due to (or as a consequence of):			
		licat		d		140	
× 68	eath certific attending p for use as t	Mec	IF FEMALE:				
Box	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year
0	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		World Say real
<u>a</u> .	hat the	Ph		entributing to death but not resulting in the u	nderlying cause given in Part I	23e Did toba	acco use contribute to the cause of death?
Records,	w requires that been signed b should be det	i by	Tarris organization of	intributing to doubt but not rosulting in the u	noonying cadso given in r air i.		3 □ Probably 4 □Unknown
Ö	requ	Completed				-	
ec ec	The law cate has b page 2 s	mpi				24a. Was an autopsy perform	prior to completion of cause of
						1 ☐ Yes 2	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Oth	ath (Check only one	
ō	Phya this al dir	T.	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Minpatient 2 LER/Outpatier			cce 6 Other (Specify)
ח	ding h. After tuner	ion	1 Swatural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time o	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe hov	virigity occurred
ISI	Nttandi death. ctor: A y the tu	ical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str		28f Location (Stre	eet and Number or Rural Route Number,
Division of	al or Attand after death Diractor: / d in by the f	Certification:	4 Homicide determined	building, etc. (Specify)	eet, ractory, office	City or Town,	State)
	urs ara		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, deat	h occurred at the time, date and place	e, and due to the cau	use(s) and manner as stated.
	ne Ho 1 24 h na Fu iletely	Medical	(Check only 2 ☐ Medical Exam one)	iner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occ	curred at the time, dat	te and place, and due to the cause(s)
	To the Hos within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, Day, Year)
	(1 Charles D	ulled 00	Res-000)	Apr. 15 2005
	11)		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type,	Print)	/	
	2		Churles Grift	ith DO Sinai	HOSPITAL OF	BAITIMON	·c
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature			
	Registr	ar	ADD 1 5 2005	HAME TO CHOOLE			

			For State Registrar	State of M		epartment o		th and Mental F ath	lygien Reg. N	C000	13028
			1. Decedent's Name (First, Midd	lle, Last)				2. Date of Month		ay Year	3. Time of Death
	Physici /Medio		Edwin H. Tho	omas, Jr.				Apri		2005	3:05 ^{a м}
	Examir	ier	4a. Facility Name (If not institution)	4b. City, Tov		tion of Death	4	c. County of Deal	
			3718 Greenvale 5. Social Security Number		ge (In yrs. last birt	hdav) If Under 1 Y	_	imore nder 24 Hrs. 8. Date of	Rinth	n/	
	Funeral Director		216-24-3655	1 (X M 2 □ F			ays Ho		Day, Yea		thplace (State or Foreign ountry) Tyland
			Usual Residence of Decedent					Parch	- T /	וסות וכל	yıanı
	show	_	10a. State 10b. Count	y	10c. City, Town						10d. Inside City Limits
	Ba-f	Director	Florida Duva	<u> </u>	Jackso	onville			-		1 Yes 2 No
	with th		10e. Street and Number 2818 Scott Mill	l Lano		10f. Zip Co	de 32223			itizen of What Co ted State	,
	eath rs 23	eral	11. Marital Status	12. Was Decedent	Ever in LLS			c Origin? (Specify Yes or		14. Race - Ame	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic svant, if a Medical Ever, if ar mast be notified at Once.	by Funeral	1 ☐ Never Married 2 🔯 Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Forces'	?	If Yes, specify 1 ☐ Yes 2 ☒		c Origin? (Specify Yes or xican, Puerto Rican, etc.) ecify:		Black, Whit	
5-(72 h "natu	etec	15. Decede (Specify only highe	nt's Education est grade completed)	16a.	Decedent's Usual O (Give kind of work of	one during	most of working	16b.	Kind of Business/	/Industry
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT use n	etired)			Marza	
d 2	filed y Hygie thar t		12 17. Father's Name (First, Middle	. Last)	PL	inter	18. N	Nother's Name (First, Mid	dle. Maide		paper
an	d be ental ked o	To Be	Edwin H. Thoma					Edith L. S		•	
ary	2 should be filed within and Mental Hygiene. Is marked othar than aumatic svant, I'm Ms	F	19a. Informant's Name/Relation		19b.	Mailing Address (St	reet and N	umber or Rural Route Nu			Zip Code)
	Health a tam 27 ls		Joanne S. Thoma	as/ Wife	28	318 Scott	Mill	Lane, Jacks	onvi	lle, Flo	rida 32223
ore,	of He of He litam		20a. Method of Disposition 1 □ Burial 2 □ € remation	2 Domewal from State	comoton	Disposition (Name of contract), crematory or other	of place)	Date	20c.	Location - City or	Town, State
Ë	Page ment ant: If ury o		'4 □ Donation 5 □ Other (Bayvie	ew Cremato	ory	4/15/2005	Ba.	Ltimore,	Maryland
Baltimore,	permit. Pages 'Department of H Important: If its any injury or ot		21. Signatur of Funeral Service	Licensee				acility Hubbard			
_	<u>v</u> ∪ = 9 9	Ш	Jel 1	Sind				Avenue, Bal		ce, Mary	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause t only one cause on each l	d the death. Do n ine.	ot enter the mode of	dying, suc	h as cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Dmel	1 cell	lun	0,0	ancen			9m3
	Examiner			Due to (or as	a consequence o	f):	0				
	BIT 343	ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence o	f):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C							
o,	an an rial-tr		resulting in death) Last		a consequence o	f):					
8760,	rate be executed physician and the burial-transit	dlcal		d.							
9	The faw requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Med	IF FEMALE:	225 16 1155 21452	of				1		
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal death	3 ☐ Ectopic pregn 5 ☐ Other (specif				23d. Date of del Month	ivery Day Year
	at the de by the tached	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	it time of death	5 □ Other (specif	y)				
P.0	that ned by deta		Part II. Other significant condit	ions contributing to death l	out not resulting in	the underlying caus	e given in F	Part I. 23e. D	id tobacco	use contribute to	the cause of death?
\S S D	n signe	d by							Yes :	2□No 3□Pr	obably 4 Unknown
00	taw requir as been si 2 should	plet						24a. W		24b. Were au	itopsy findings available
Ä	The transition of the transiti	Completed							utopsy erformed? s 221N	death?	completion of cause of
Vital Records,		Bec	25. Was case referred to medical examiner?			-		Place of Death (Check on			
of V	Physician: this certific ral director,	P.	1 ☐ Yes 2 No	Hospital: 1 🗌 Inpati				Nursing Home 5 R			
n		iuo	27. Manner of Death Natural 5 Pendi		ury 28b. T ay Year) Ir	jury	Injury at Work?		oe how inj	ury occurred	nome
Sio	Nttendi death. ctor: A y the fu	icat	2 Accident invest	not be	ium. At homo for	M otrock forter of	1 □ Yes		n /Stmat	and Number or D	ural Route Number,
Division	lor Att after d Diract I in by I	Certification;	4 Homicide determination	mined 286. Place of the building, e	tc. (Specify)	m, street, factory, of	IIC O	City or	Town, Sta	te)	arai noute Number,
_	To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune		29a. Certifier	ng Physician: To the best	of my knowledge.	death occurred at the	ne time dat	te and place, and due to t	he cause(s) and manner as	stated
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medica one)	Exeminer: On the basis of and manner s	of examination and	Vor investigation, in	my opinion	death occurred at the tin	ne, date a	nd place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	er .		29c. Li	cense num	ber	29d. D	ate signed (Monta	h, Day, Year)
)			P CON O	M		1	135	254	4-	-13-6	5
/x	d		30. Name and address of person	who completed cause of	death (Item 23a) (
5			Carole Mil	1+r 900 (aten (Que BA	LTIV	none My) 2	1229	
	Sta	-	31. Date filed (Month, Day, Year APR 1		rar's Signature						
Du	Registr MH 17 Rev 1/2	100	MINI	5 2005	ever St	Sparke					
טחו	*** 17 NEV 1/2	JUI			ORIG	INAL					

			1 _ Stete		artment of Health and I	Mental Hygier	1e
			Registrar 1. Decedent's Name (First, Middle, Last)		Tillicale of Dealif	Reg. I	No. U 3. Time of Death
	Physici	an	24 L A			Month (Day Year
	/Media		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Deat		L2, 2005 7:00P. M
	Examir			and number)			4c. County of Death
	Formul		1643 HEATHFIELD ROAD 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	BALTIMORE If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign
	Funeral Director		220-74-4407 10M:		Months Days Hours Min.	(Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country) 7 MARYLANA
			Usual Residence of Decedent	* (1.70 5 0	of Innikitation
	the Maryland r 28a-f show		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	B Ma	cto	MD	BALTI	MORE		1 X Yes 2 □ No
	with the Maryland is or 28a-f show	Olre	10e. Street and Number	O_{I}	10f. Zip Code	10g.	Citizen of What Country?
	ath w	ral	1643 Heathfield	Kd.	21239		USA
	ler dea	Funeral Director	A	as Decedent Ever in U.S. 13. med Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	', or	by F	1 ☐ Never Married 2 ☐ Married 1 If 3 ☐ Widowed 4 ☐ Divorced Y.	☐ Yes 2 No Yes, Give ear or Dates:	1 ☐ Yes 2 No Specify:		Specify: In his la
5-0036	172 hours after death *neture!; or Items 23		15. Decedent's Education		dent's Usual Occupation	16h	. Kind of Business/Industry
5	n ne	Completed	(Specify only highest grade com	pleted) (Give	kind of work done during most of wo DO NOT use retired)	rking	. Talled of Submission industry
2121	Hygiene. Hygiene. ther than	E O	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	tress		ennus
b	illed within I Hygiene. other than sent. the M	Be C	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	len Sumame)
<u>a</u>	buld be Mental arked o	To B	Donald L. Phi	11:05	Doco	thu A.	Ewina
Maryland	ds E E		19a. Informant's Name/Relationship (Type, P	rint) 19b. Maili	ng Address (Street and Number or Ru	iral Route Number, Cit	y or Town, State, Zip Code)
_	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny injury or other tra ance.		Martha Phillips	-Dister 2400	Burridge Rd.	BALTIMON	VEZIZ (M) ZIZZY
Baltimore,	item		20a. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State
Ĕ	Page hent int: If		1 ☐ Burial 2 Ø Cremation 3 ☐ Remov	at from State		6-05 F	rest Hill MD
atti	permit. Departn Imports eny inju		21. Signature of Funeral Service Licensee	2:	2. Name and Address of Facility	torinoRE	MO 21234
B	4 4 E 5 8		Kinbera (1. %	shotte Fr			HARFORD RD.
	ĸ		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death. Do not en		7 7	Approximate Interval Between
	Pnysician :		Immediate Cause Final disease or condition	Head 1	'4 Juns		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	4		
н	Examiner		Sequentially list conditions, b				
,	De is	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
to.	and I-trans	кат	that initiated events c	Due to (or as a consequence of):			
8760,	centificate be executed Iding physician and Ise as the burial-transit			Due to (or as a consequence or).			
	ate 1ys he	dical	d			-	
9 X	eath certific attending pl for use as t	/Me	IF FEMALE: 23c. If	yes, outcome of pregnancy			23d. Date of delivery
Вох	atter for u	ciar	in the past 12 months?	Live binth 2 🗌 Fetal death 3[Ectopic pregnancy Other (specify)		Month Day Year
P.O.	the d y the iched	Physician/Med		Unknown			
	requires that the death een signed by the atter nould be detached for u		Part II. Other significant conditions contribut		nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
rgs	quire; n sig	g p	Chronic alcoh	of abuse		1 🗆 Yes	2 No 3 Probably 4 Unknown
00	> 4	lete				24a. Was an	24b. Were autopsy findings available
Division of Vital Records,	0 4 9	Completed by				autopsy performed	
ta	i cien: Th certificate rector, pag	a	25. Was case referred to medical		26 Place of Dea	1 Nes 2 □ I	No Yes 2 No
<u>></u>		To B	examiner? 1XX Yes 2 ☐ No Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Outpatie		lome 5 Residence	6 (Nother (Specify)
0	ding Phys h. After this funeral di		27. Manner of Death 28	a. Date of Injury (Month, Day Year) 28b. Time o		28d. Describe how in	
Ö	Attending I r death. ector: After by the funer	atlo	2X Accident investigation For	mel 4/12/05 Found 18:		Subject fe	il dows Steps
<u>\S</u>	er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28	e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, Str	and Number or Rural Route Number RM ate) 1643 # 104 ft fill RM
Ö	itel o	Certification:		At U	ione	Baltin	of Mity MO
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only Medicel Examiner: C	on the basis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause irred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	nd mannur statud.	29c. License number	29d. I	Date signed (Month, Day, Year)
	⊢≯≓ŏ		7.1.1.1.1.6	ser	OCME		
	6		30. Name and address of person who complete	red cause of death (Item 23a) (Time	Print	API	RIL 13,2005
	Ų		DMILL (AA)	AG (1908,		et Baltim	ore, Maryland 21201
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature			, LALLY TOLING LILLOT
15	Registi		APR 1 5 2005	Brewn A So	arte!		

			1 - For State Registrar	State of M	aryland / Depa		of Health and of Death	-	giene Reg. No.2	005	3030
Dh	rysicia		1. Decedent's Name (First, Middle, Las					2. Date of De		Year	3. Time of Death
	Medic			TUROS		,		APRIL	Day 13	2005	1:42 PM
E)	kamin	er	4a. Facility Name (If not institution, give	street and number,)		m, or Location of D	Death		nty of Death	
			8414 Mitzy Lane 5. Social Security Number 6. S	av 7 A	ge (In yrs. last birthday)	If Under 1 Yo	ott City ear If Under 24	Hrs. 8. Date of Birt	Howa		lana (Stata or Forniga
	neral ector			2 M 2 □ F	76 Yrs.			Min. (Month, Da	y, Year)	O	lace (State or Foreign try) V Jersev
and		}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		-		11	Od. Inside City Limits
Maryl -1 sho	ied a	ţo	MD Howard		Ellicott (City					1 □Yes 2 No
h the	noti	Funeral Director	10e. Street and Number			10f. Zip Cod	de		10g. Citizen	of What Coun	try?
th wit 23a o	dia	ai D	8414 Mitzy Lane	2		2.	1043		US	A	
r dea	BL THE	ner	11. Marital Status	12. Was Decedent Armed Forces	?	Was Decedent	of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)	14. F	Race - Americ Black, White,	
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-f show	мати	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No Navy	1 □ Yes 2 🔀		,	Spe		ite
21215-0036 d within 72 hours aff giene.	Sale	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc	ccupation		16b. Kind of	Business/Inc	lustry
1215 within 7 ene. than "n	Med	Completed	(Specify only highest gra	de completed) College (1-4or	life	kind of work do DO NOT use re	one during most of stired)	f working			,
d 21 filed will Hygien ther th	2	Con	12	4	· .	ctrical	Engineer				ustries
tal Hypoth	@Ven	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,			
aryla should and Men	natic	၉	John Turos	5 0 1				ziszka Dro	· · · · · · · · · · · · · · · · · · ·		
Maryland of 2 should be file th and Mental Hy 27 is marked oth	traun		19a. Informant's Name/Relationship (Jean Turos - wife		E .			or Rural Route Numbe licott Cit	-	vn, State, Zip 21043	Code)
Te, N 1 and Health tem 27	other		20a. Method of Disposition	•	20b. Place of Dispo	sition (Name o	of .	Date	4 .	on - City or To	wn, State
Pages nent of int: If it	yord		1 Surial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific		Meadowri	matory or other doe Mem		/16/2005		idge, M	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Igne 27 is marked other than "natural; or Items 23a or 28a-1 show	any injur once.		21. Signarore of Funeral Service Licen	·	G	2. Name and Acary L. I	ddress of Facility Kaufman I	Funeral Ho	me@Me	adowri	dge MP, Inc.
Division			23a. Part1. Ente disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each l	d the death. Do not en	er the mode of		Blvd., Elk rdiac or respiratory ar		MI) 2.	Approximate Interval Between Onset and Death
Physic /Med Exam	lical		disease or condition resulting in death)	a	s a consequence of):						5 MONTHS
ocuted A	transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of killury that initiated events	Due to (or as	s a consequence of):						
58760, icate be exe	he bu	cal	resulting in death) Last	Due to (or as	s a consequence of):						
Box (ath certif	tached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregna Other (specify				Date of delive Month	ry Day Year
rds, P quires that on signed b	d be de		Part II. Other significant conditions of HY PERTEUSION	ontributing to death I	A		e given in Part I.		obacco use co /es 2 🗆 No	. /	e cause of death? ably 4 DUnknown
Vital Records, sician: The law requires t certificate has been signe	page 2	Completed by						24a. Was autop perior 1 Yes	sy	prior to con death?	osy findings available inpletion of cause of 2 \square No
Vital Fician: The Certificate	actor.	Be	25. Was case referred to medical examiner?	Magaita!:				Death (Check only o	ne)		
on of \ ding Physi h. After this o	funeral dir	2	1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpati 28a. Date of Inju (Month, Da		28c. i	Other: 4 Nursin	28d. Describe h	lence 6 🗆 0)
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled in by the	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, farm, str tc. (Specify)			28f. Location (S City or Tow	Street and Nu vn, State)	mber or Rurai	Route Number,
he Hospit in 24 hour he Funers	pletely fill	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Certifying Ph 2 Medical Exem	y sician: To the best niner: On the basis of and manner si	of my knowledge, deat of examination and/or in tated.	h occurred at th vestigation, in n	ne time, date and p my opinion, death o	place, and due to the o occurred at the time, o	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
To t Withi	COB	Σ	29b. Signature and title of certifier			1	cense number		29d. Date sig		
			> Typu is			77	38296		XPRIC	14,	2005
let	1		30. Name and address of person who	5, MD 95	010C) ANN		AD, ELI	LI (077 (17y	, us	2104	12
Re	Sta		31. Date filed (Month, Day, Year) APR 15 2	005 32. Gegist	rar's Signature	roule	,				

	1 - For Stata Registrar	State of Maryland / Dep Ce	artment of Health and I	, ,	ene No2005 3032
Physician	Decedent's Name (First, Middle, Last) SHEILA DELORES	WEST		2. Date of Death Month APRIL	Day Year 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give s ST AGNES HOSPITAL		4b. City, Town, or Location of Deat BALTIMORE CITY		12, 2005 6:56a 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday.		(Month, Day, Y	
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	01-31-194	10d. Inside City Limits
the Marylan 128a-f show Lodfilled at irector	MD NA	BALTIMOR			1 ✓ Yes 2 ☐ No
with the Mar ta or 28a-f sh Les multified	10e. Street and Number 135 N. GRANTLEY	ST.	10f. Zip Code 21229	10g	. Citizen of What Country? USA
Site death virtues 234	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
Ind 21215-0036 be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Itams 23a or 28a-f show avant. If a Modical Examinating must be notified at Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕰 No Specify:		Specify: BLACK
21215-00 ed within 72 hou ygjene. Per than "natura t. If y Modical Completed	15. Decedent's Edu (Specify only highest grade	Give (Give	edent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	rking 16	b. Kind of Business/Industry
d 212 filled with Hygiene. ther than int, tre h	Elementary/Secondary (0-12) 12 TH GRADE	L VRS SUPE	RVISOR		ommunications
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or traumatic avant, If a Modical Exert To Be Completed by F	17. Father's Name (First, Middle, Last) AUTHUR WEST		ERMA	ne (First, Middle, Ma RYAN	iden Sumame)
Maryla d 2 should th and Men th and Men traumatic	19a. Informant's Name/Relationship (Ty, SHELAE WATKINS	1.1	ing Address (Street and Number or Riv V. GRANTLEY ST.		
or Heal	20a. Method of Disposition 1 🗗 Burial 2 🗆 Cremation 3 🗆 R	20b. Place of Disp	osition (Name of practory or other place)	BALTO . 1 Date 20	c. Location - City or Town, State
.⊑ a a a a c	'4 □Donation 5 □Other (Specify) 21. Signal re of Funesal Service License	ARBUTUS	2. Name and Address of Facility		ALTO MD
Balt permit. Departr Imports any inji	+ Dayoh C	J y	2. Name and Address of Eacility PUGHN C. GREENE FW 151 BALTO, NATT PIKE	, BALTO . M	0 21229
Physician	shock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do not en le cause on each line. Athorosclessfic			t, Approximate Interval Between Onset and Death
/Medical Examiner	disease or condition resulting in death)	Due to (or as a consequence of):	TO VOICE OF SCHOOL	di Lendx	
ner de	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
8760, rate be executed hysician and the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
18760, cate be exphysician at the burial dical Ex					- Shan
Box 61 leath certific attending p	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transitication: To Be Completed by Physiclan/Medical Examir	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☒ Unknown		Other (specify)		Month Day Year
IS, Pres that signed be detailed by President by Presiden	Part II. Other significant conditions con	stributing to death but not resulting in the t	underlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ሺ Unknown
al Record The law requir cate has been si page 2 should				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
al Recarded to the large at the				autopsy performe 1 Yes 2	d? prior to completion of cause of death? No 1 □ Yes 2 □ No
of Vita hysician: his certific Il director,	25. Was case referred to medical examiner? 1X Yes 2 No	ospital: 1 ☐ Inpatient 2XX €R/Outpatie		ath (Check only one)	ce 6 □Other (Specify)
on of ding Ph h. After th funeral	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physic	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Divi	29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my knowledge, deal ner: On the basis of examination and/or in	th occurred at the time, date and place	e, and due to the caus	se(s) and manner as stated.
To tha H within 24 To the F complete	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		. Date signed (Month, Day, Year)
4	> hij hi	, m.D	OCME	AF	PRIL 12, 2005
40		mpleted cause of death (Item 23a) (Type,		et Baltir	more, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1. 1.		
DHMH 17 Rev 1/2001	APR 1	5 2005 Januar 15	1900er		

ORIGINAL

			1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygien		
	Physic /Medi		1. Decedent's Name (First, Middle, Last	S. WARD		2. Date of Death A Month	Pay Pear G : 15 P.M	
	Examir	ner		HOSPITAL CEN	TXTT DITOUT	WN	C. County of Death BACTIMORE	
	Funeral Director		5. Social Security Number 6. Se 219-28-0893 18 Usual Residence of Decedent	7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hr Yrs. Months Days Hours Mir		9. Birthplace (State or Foreign	
	Maryland -f show	tor	10a. State 10b. County Baltimo		Randeulston	IM)	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	with the	I Direc	10e. Street and Number 9931 -Hov+ Curc		10f. Zip Code		Citizen of What Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-1 show any injury or other traumatic event. The Madicial Examination must be mortified at Once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amgd Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Clban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: ALOV	
21215-0036			15. Decedent's Edu (Specify only highest grad	cation 16 e completed)	5a. Decedent's Usual Occupation (Give kind of work done during most of w life. QO NOT use retired)	orking 16b.	Kind of Business/Industry	
		Comp	17. Father's Name (First, Middle, Last)	College (1-4or 5‡)	Mail Handler		ederal Government	
Maryland		To Be Completed by Physiclan/MedIcal Examiner	Ernest Navo	roe Priot)	9b. Mailing Address (Street and Number or F	a Johnson)	
			Beatrice Ward 20a. Method of Disposition	(WIFE) C	1931 Hot Circle	Kardallsta		
Baltimore			1 B/Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	vison Furest 4-	18-05 OL	Viras Mills, MD	
Ba			Daugh C.		8728 Liberty Ko	t Kandalle	eent uneral Services Stown MD 21183	
			Immediate Cause (Final disease or complete Cause (Final disease or condition resulting in death)	ne cause on each line.	o not enter the mode of dying, such as cardia		Approximate Interval Between Onset and Death	
	/Medical Examiner		Sequentially list conditions	AR DISEA	38.			
6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C					
68760,			(d				
P.O. Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year		
rds, P	quires that n signed b		þ	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
	Hospital or Attending Physician: The law request At hours after death. Funeral Director: After this certificate has been tely filled in by the funeral director, page 2 should be after the funeral director.		ATRIAL FIBR	ILLATION		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
of Vita			0 8	25. Was case referred to medical examiner?		Othor	ath Check on one	6 □Other (Specify)
ion o			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Time of lnjury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how inju	ury occurred	
Division	tal or Atters after de al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, State	ind Number or Rural Route Number, te)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	e, and due to the cause(surred at the time, date an	s) and manner as stated. Id place, and due to the cause(s)	
)	within 2 To the complet	Σ	29b. Signature and the of certifier	1 HYSICIAN	29c. License number 4 2 7 2 3	AFR		
	10		30. Name and address of person who co	mpleted cause of death (Item 23a	(Type, Print) NORTHWES	COURTRO	AP MD 21133	
	Sta Registr		31. Date filed (Month Pay, Year) 20	32 Registrar's Signature	Jan 18 1			

			_	State of							lental Hygi	•	ic.	
			1 - For State Registrar		,	•	rtificate					g. No.2 0 0	5	13034
	Physici	on										3. Time of Death		
	/Medic		Frances					Worrell April 7				2005		1:05 p M
7	Examin	er	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of N/A	Death		
	Funeral		5. Social Security Number		. Age (In yrs. I	last birthday)	II Under	1 Year	If Under :		8. Date of Birth	1	Birthp	lace (State or Foreign
	Director		217-28-8470	1 ☐ M 2 🛣 F	75	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Aug. 22	, 1929	Mary	lace (State or Foreign try) Land
	and		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Mary First	tor	MD	N/A	В	Baltimo	ore							1 ☐ Yes 2 ☐ No
	or 288	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of Wh	at Coun	try?
	ath wi	rail	1619 East Madi			-	212					USA		
	ter de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Deced Armed Ford rried 1 ☐ Yes 2	es?	S. 13.	Was Deced If Yes, spec	ent of Hi fy Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	White,	
Maryland 21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Examinational Legiculified at	by	3 ☐ Widowed 4 ♣ Divorced If Yes, Give Year or Dates:					1 ☐ Yes 2 ☑ No Specify:				Specify:	В1	.a c k
5-0	72 ho	To Be Completed	15. Decedent's Education (Specify only highest grade completed) [Give Kind of work done during most of working life. DO NOT use retired) [Give Kind of work done during most of working life. DO NOT use retired)						6b. Kind of Busi	ness/Ind	dustry			
121	within ene. than		Elementary/Secondary (0-12) 11th	College (1-4	4or 5+)		orer	e retirea,	,			Texti	1e 1	Factory
d 2	other other		17. Father's Name (First, Middle	, Last)					18. Mothe	r's Name	(First, Middle, M			
ylar	Menta Menta arked atic e		John Daniel Marshall Mary Amelia Smoot						ot					
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mardical Examinating the multiple at once.		19a. Informant's Name/Relation Kenneth Worre1				-				Baltimo:			
	tem 2		20a. Method of Disposition	.+ (5011)	20b. P	lace of Disno	eition /Nam	o of				Oc. Location - Ci		
Baltimore,	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (tate Bal	emetery, crer timore Loud	Crem on Pa	ator	у /	4/14	/05 B	altimore	, M.	aryland
Salti	permit. Departr Imports any inju		21. Signature of Funeral Service	Licensee		22	. Name and	d Addres	s of Facility	-	oudon Pa	rk Fune	ral	
	⊈ O P ≤ O	ical Examiner	23a. Parti-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
	Physician		Immediate Cause (Final	. A			-			cardiac	ir respiratory arre.	ı.,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) A Myocardial Infarction Due to (or as a consequence of):											
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes mellitus, type Diabetes mellitus, type Diabetes mellitus, type Diabetes mellitus, type						risea	, ease			1	0 years
(10	ted nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Diabetes melli					this time 7					1	3 years
~ ~	te be executed ysician and te burial-transit		resulting in death) Last C. Due to (or as a consequence of):							1	Jyenis			
3760,	# × •		B Hypertension											
x 68	ires that the death certifica signed by the attending ph d be detached for use as th	/Med	IF FEMALE:	23c II vas oute	ome of pregna	nov								
Вох	atten affor us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 No 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregrate 4 Pregnant at time of death 5 Other (specific									23d. Date of delivery Month Day Year		
P.O.	at the c by the tached	ompleted by Physician/Med	9 □ Unknown 9□ Unknown											
	The law requires that the tite has been signed by this age 2 should be detache		Endometr	. 1			nderlying ca	luse give	n in Part I.		_	-		e cause of death?
Sorc	v requii been s should			arcinoma							1 Tes			ably 4 □Unknown
of Vital Records,	The law ate has page 2:	duic	Dreast Ca	arcinovna							24a. Was an autopsy perform	ed? prid	or to con	psy findings available inpletion of cause of
ita		To Be C	25. Was case referred to medical	al					26. Place	ol Death	1 ☐ Yes 2 1 (Check only one		Yes	2 NO
of V	S S		examiner? 1 Yes 2 No			ER/Outpatien			4 🗀 1901		me 5 Resider)
ou o	ding h. After fune		27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Injury at Work? 1 Pending investigation 3 Suicide 4 Homicide 4 Homicide 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Describe how injury occurred 28b. Injury at Work? 1 Yes 2 No 28b. Injury at Work?											
Division	or Attending after death. Director: After in by the fune	ifica								or Rurai	Route Number,			
Ö	rtal or rs afte ral Dir	0	4 Hornicide Building, etc. (Specify)											
	Hosp 24 hou Fune Hely fill	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the b I Examiner: On the bas and manne	sis of examinat	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the car ed at the time, da	use(s) and mann e and place, and	er as sta d due to	ated. the cause(s)
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29b. Signature and title of certific		, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		29c.	License	number		29	d. Date signed (Month, L	Day, Year)
)			PEdit N	1. Vaco	MD			D5	077	0	A	pril 12	2, 3	2005
	X		290. Signature and title of certifier Edith M. Vargo, MD 1000 E. Eager Street, Baltimore, MD 21202 31. Date filed (Month, Day, Year) 32. Registrar's Signature											
	Sta	ite	31. Date filed (Month, Day, Year) 32. Re	pistrar's Signal	ture	· cag	41	JITER	-1, !	ON TOWNS	ve, vii		
	Registr		APR	1 5 2005	Colum	K	boath							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #20b PER FH C842 4715/05 JE Reg. No. . Decedent's Name (First, Midd 2. Date of Death 3. Time of Death **Physician** Rutha Mae Waller 7AM /Medical 3 2005 Hori 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CAMBRIDGE
If Under 1 Year If Under 24 Hrs. HOSPITAI DURCHESTER GENERAL NORCHESTER Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 7 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 K F Months Days Hours Min. Director 75 Vre NC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ahow ust be nutified at MD Dorchester Vienna Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4912 Old Route 50 21869 United States 230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumetic avant, the Medical Examiner 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married P 1 Tes 2 No Specify þ Specify: Black 3X Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is markad othar than ' Elementary/Secondary (0-12) College (1-4or 5+) Direct Care Aide State Facility 10 17. Father's Name (First, Middle, Last) Armond Flowers 18. Mother's Name (First, Middle, Maiden Surname)
Della Kersey Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jannard G. Rideout-Daughter 2112 E. Fayette St. Balto. MD. 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Apr 18 permit. Pages:
Department of H
Importent: If ite
any injury or ot
once. $\frac{20}{20}$ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MDVA Cemetery-E.S. 2005 Hurlock, MD. 21. Signature of Funeral Service Cense Ca Name and Address of Facility liams Funeral Service P.A. P.O. Box 11651 21229 Baltimore, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Probable Acute MYDCUTO INFARCTION disease or condition 30min /Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary 10 years Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed It reference of): burialphysician a Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 46 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autonsy performed? 1 🗌 Yes 2 110 2/11/0 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ №6 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Box 68760, P.O. | Division of Vital Records, Hospitel or Attanding Physician: filled in by the within 24 hours a To the Funeral L completely the 0

Baltimore, Maryland 21215-0036

Medical 29b. Signature and title of certifier Timothy

(Check only one)

State Registrar SNIEZEK

MO

D0053253

SUIK

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AUE

29c. License number

29d. Date signed (Month, Day, Year)

21655

Preston, MD

MO

30. Name and address of person who complete of ause of death (Item 23a) (Type, Print) 136 Lednum

MD

32 Registrar's Signature

31. Date filed (Month, Day, APR 1 Year) 5 2005 It spork

1/2

			State of Maryland	d / Department of I	Health and Me	ental Hygiei	ne	
		for State Registrar	Otato of marytaire	Certificate of		Reg.	71115	13036
	u _i	Negistrar Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physic		Earl Preston Zepp	.Tr.			Month April 8,	Day Year 2005	6:50 a M
/Medi Exami	- 65	4a. Facility Name (If not institution, give s		4b. City, Town,	or Location of Death		4c. County of Death	
		801 Hilltop Rd.		Catonsv			Baltimor	e
. Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
Director		212-20-9194 Usual Residence of Decedent	7.8	115.	Ji	ıly 22, 1	926 Mary	land
land ow		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
Mary -feh	tor	MD Baltimore	e Cat	onsville				1 □ Yes 2 □ No
death with the Maryland ims 23s or 28e-f ehow	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
1h wit		801 Hilltop Rd.		2122			USA	
r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	 13. Was Decedent of If Yes, specify Cui 	Hispanic Origin? (Spec ban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White,	
36 safte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2☐No	Specify: whit	te	Specify: wh	ite
ING 21215-0036 be filed within 72 hours after death with the Marylan hall Hygiene. dother than "natural", or items 23s or 28e-f show event, the Madicul Executer frontitied at	edk	15. Decedent's Educ	cation	16a. Decedent's Usual Occu	upation		. Kind of Business/In	dustry
715 27 nin 72 27 nin 72	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retin	e during most of workin ed)	9		
d will	Completed	12		Insurance Age			tionwide	Ins.
be filed tral Hygi of other	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name		den Surname)	
larylan 2 should be and Menta Is marked eumatic ev	2	Earl P. Zepp Sr.		101 11 11 11 11 11 11 11	Mary Grad		tura Taura Stata 70	- Codel
Maryland d 2 should be file th and Mental Hy t7 Is marked oth treumatic event		19a. Informant's Name/Relationship (Ty) Donna Lee Leister-		19b. Mailing Address (Street 1800 Shawan V				
		20a. Method of Disposition	20b. Pl	lace of Disposition (Name of	Da		Location - City or To	
Pages Pages nent of nnt: If It		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State Balt	emetery, crematory or other pla imore Cremato Ion Park	ry @	11 05 Ba	ltimore C	4+0
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item any injury or othel		21. Signature of Funeral Service License			ress of Facility Loud	Charles and the Control of the Contr		
Departiment of the control of the co		Kim Ack	Panou		ens Ave. Ba			
*		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that saused the death ne cause careach line.	. Do not enter the mode of dy	ring, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	GONGE	TIVE CA	+RDION	Lyopx	J249	Ganre
/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):			,	,
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	uence of):				
ried nsit	를	Cause (Disease or injury						
760, ((f)	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	jence of):				
2 2 2 2	icai		d					
→	Med						1	
OX h cer endir use		IE EEMALE:						
m	lan/	23b. Was decedent pregnant	23c. If yes, outcome of pregnar	death 3 Ectopic pregnan	су		23d. Date of deliv	ery Day Year
O. B ne deat the attr	ysician/			death 3 Ectopic pregnan	су			
that the deat ed by the att	y Physician/	23b. Was decedent pregnant in the past 12 months? 1 \(\times \) Yes \(2 \) No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnan- eath 5 Other (specify)		23e. Did tobac		Day Year
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			1 - For State Registrar	State of M	Maryland /		artment of He rtificate of D			ene 005	13037
	Physici /Medi		Decedent's Name (First, Middle, IVIRGINIA M.	ast) ALEX					2. Date of Death Month APRIL 17) Day Year	3. Time of Death 4:10 P. M
	Examir		4a. Facility Name (If not institution, g		•		4b. City, Town, or Lo	ocation of Death		4c. County of Death	1
			OAK CREST VILL 5. Social Security Number 6.		CENTER Age (In yrs. last b	inth day)	PARKV	TLLE If Under 24 Hrs.	8. Date of Birth	BALT	
ı	Funeral Director		218-14-8794	1 □ M 2 □ X	80	Yrs.		Hours Min.	12-7-19	Year) 9. Bint 24 1.	nplace (State or Foreign untry) MARYLAND
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	ocation				10d. Inside City Limits
	Mary F-f sh	tor	MD	CECIL			ELKT	ΟN			1 ☐ Yes 2 ☐XNo
	ith the	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23s	rai	250 WOODS WAY	T 40 W 5		1	_1	1921			J.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Example Invitibulations.	by Funeral	Narital Status Never Married 2 Married Married 2 Married Married 2 Divorced	12. Was Deceder Armed Force: 1 Yes 2 [If Yes, Give Year or Dates	s? X No		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 【XNo	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: [M	
رم ح	72 hou nature ical E	ted	15. Decedent's	Education		a. Dece	dent's Usual Occupation	on	, _ 1	6b. Kind of Business/I	ndustry
21215-0036	within 7 iene. than "r ins Med	Completed	(Specify only highest g Elementary/Secondary (0-12) 12	College (1-4o	r 5+)	life.	kind of work done dur DO NOT use retired) MEMAKER	ing most of worki	ing	OWN HOM	æ
	e filed al Hygi other vent,	BeC	17. Father's Name (First, Middle, Las	t)		110		8. Mother's Name	e (First, Middle, M		IE:
Maryland	sould by Ments	To E		EBRON				JENNIE	`	POPERA)	
	aith and 27 is n		19a. Informant's Name/Relationship JANET LANTIERI				ng Address (Street and WOODS WAY		N, MD	City or Town, State, Z. 21921	ip Code)
altimore,	iges 1 and of He		20a. Method of Disposition 1 Survival 2 Cremation 3		comoto	of Dispo	sition (Name of natory or other place)	1		Oc. Location - City or T	
altir	mit. Pa partmer sortant / injury		*4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic		ST. S		ISLAUS CEM . Name and Address of		-2005 CH/ROSED	BALTIMORE ALE FUNERA	
m	Depared Important Importan		Sha	L U	<u></u>		1211 CHESA	CO AVENU	E ROSED	ALE, MD 2	1237
Г			23a. Part1. Enter the disease, or conshock, or heart failure. List oni	nplications that caus y one cause on each	ed the death. Do line.	not ent	er the mode of dying,	such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		cteria l		preso	nonia			
L	Examiner		Sequentially list conditions,	b	is a consequence	1017.					
	ted	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence	of):					
o,	execuin and ial-trai	Exan	that initiated events resulting in death) Last	Due to (or a	s a consequence	of):					
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical		d							
_			IF FEMALE:	23c. If yes, outcom	e of preopage						1
P.O. Box	0 0	Physician/M	23b. Was decedent prognant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	Pery Day Year
	res that igned b be deta	by P	Part II. Other significant conditions	contributing to death	but not resulting i	in the ur	nderlying cause given i	n Part I.	23e. Did toba	acco use contribute to	the cause of death?
ä	w require been sig should b	ted	atrial (11:20:11					1 Tes	2 □ No 3 □ Pro	bably 4 Unknown
Vital Hecords,	The la ate has page 2	Completed	corebral	Vasco) lar	Ċ	disease		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
ZI S	nysician: Th	Be	25. Was case referred to medical examiner?	Hospital:					Check onl one		
Ö	Phys er this eral di	: To	1 ☐ Yes 2 ☐ No 27. Manney of Death	1 ☐ Inpat 28a. Date of In (Month, D	tient 2 ☐ ER/Oi jury 28b.	utpatien Time of	28c. Injury at	4 Nursing Hor	ne 5 Residen 28d. Describe how	ce 6 Other (Special	ify)
000	ttending death. ctor: After y the funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	n	ay Year)	Injury	28c. Injury at Work? M 1 ☐ Yes	2 □ No		,,	
DIVISION	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately tilled in by the funeral director, tely tilled in by the funeral director.	Certification:	3 Suicide 6 Could not determined	28e. Place of It	njury - At home, fa etc. (Specify)	arm, stre	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or Attant within 24 hours after deatt To the Funeral Director: completely filled in by the	edical	29a. Centifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manners	or examination ar	e, death nd/or inv	occurred at the time, restigation, in my opinion	date and place, a on, death occurre	and due to the cau ed at the time, dat	ise(s) and manner as see and place, and due l	stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier				29c. License no		290	d. Date signed (Month,	Day, Year)
^	~		an mo		, M.D.	_	D546	46	A	Pc:/ 18	2005
1			30. Name and address of person who				- Boule	(22 24)	00-1-11	6 mis	17.31
	Sta		31. Date filed (Month, Day, Year)	32 Regis	trar's Signature	-	- 100 (E	Ja 10	40.	- (())	-1
	Registr	ar	31. Date filed (Month, Day, Year) APR 1 8 2	005 Bloom	w B,	400					

Patient known as Oscar Alexander Baltimore Maryland 21215-0036

	Ph //\ Ex
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed
6	11

				Please	Type or Prin							.egible.		
			For State Registrar		State of Ma	aryland		artment of <i>tificate o</i> i	Health and I f <i>Death</i>		giene Reg. No.	005	13038	
	Physici		1. Decedent's Name (Fi	irst, Middle, Lasi	")		Al	LEXANDEF	}	2. Date of De		Year 2005	3. Time of Death	
)	/Medic Examin		4a. Facility Name (If not	t institution, give	2 11.			0 11'	or Location of Deat		4c. 0	County of Dea	N/A	
Ī	Funeral Director		5. Social Security Number 027-24-18		DalTIMOT X 7. Age ZM 2□F	ન્દ ∍ (In yrs. Ia 90	ist birthday) Yrs.	If Under 1 Year Months Day	r If Under 24 Hrs		r 1914	9. Bir	thplace (State or Foreign country) RUSSIA	7
	ס		Usual Residence of De			10c. City	Town or Lo	cation					10d. Inside City Limits	_
	Manyla -f sho	to	MD	N/A		,		IMORE					1 NYes 2 □ No	,
	or 28a	Director	10e. Street and Number	r				10f. Zip Code			10g. Citiz	en of What C		
	leath w	Funeral	2500 W. E	BELVEDER	E AVENUE 12. Was Decedent 6			Was Decedent of	21215 Hispanic Origin? (Suban, Mexican, Puer	pecify Yes or No)- 1·	4. Race - Am		
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatih and Menial Hygiene. Depertments if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at angle.	þ	1 Never Married 3 Widowed 4	.,	Armed Forces? 1 ☐ Yes 2 🐧 N If Yes, Give Year or Dates:	10		fYes, specify Cu 1 □ Yes 2 ሺ N		to Rican, etc.)		Black, Whi	WHITE	
5	"natu	letec	15. (Specify o	Decedent's Ed	de completed)		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of wo	rking	16b. Kin	d of Business	/Industry	
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	be file ital Hy id othe event,	Be	17. Father's Name (Firs	st, Middle, Last)		ΔI	EVAND	ROVICH	18. Mother's Nam	me (First, Middle	, Maiden S	Sumame)	ROISMAN	
II y	should nd Mer marks matic	ဥ	I SAAC 19a. Informant's Name	/Relationship (7	ype, Print)	AL			et and Number or Ru	ural Route Numb	er, City or	Town, State,		
, Me	and 2 :		DANIEL AL	EXANDER	R / SON				ROAD WES			RONXVIL)8
ע	Pages 1 nent of He int: if Iten iry or oth			remation 3	Removal from State	Çe	metery, crer	sition (Name of natory or other p		Dete		ation - City or		
	permit. Pa Depertmer important any injury		*4 □Donation 5 □ 21. Signature of Funera			BEI		LUH CEMI . Name and Add	ETERY 04/1	DL LEVIN		ODLAWN BROS		_
ă	Depermi Depermi Import any ir		Rolo	6/5	Troum	\geq			STERSTOWN	ROAD -	PIKES		MD 21208	
F	hysician		23a. Part1. Enter the d shock, or heart fa Immediate Cause (Final disease or condition resulting in death)		a Pneum	onia		er the mode of d	ying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 7 day 5	
ı	/Medical Examiner			ſ	Due to (or as	a consequ	ence of):							
	ii d	iner	Sequentially list conditi if any, leading to imme cause. Enter Underlyin	ions, diate ng	Due to (or as	a consequ	ence of):							
	be executed sician and burial-transit	Examiner	Cause (Disease or inju that initiated events resulting in death) Last	lry .	c Due to (or as	a consequ	ence of):							
000	ate be e nysiciar he buri	<u>a</u>		·	d									
0 Y O	certifica iding ph	/Med	IF FEMALE:		23c. If yes, outcome	of pregnar	ncy				2:	3d. Date of de	livery	
5	t the death by the atter ached for u	Physician/Medic	23b. Was decedent pre in the past 12 mor 1 Yes 2 No 9 Unknown	nths?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnar Other (specify)	ncy			Month	Day Year	
olds, r	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	by	Congestive	Heart	Failure	ut not resu	Iting in the u	nderlying cause (grven in Part I.			e contribute t	o the cause of death?	1
מבר ב	has be	Completed	Parkinson	's Disea						24a. Was	DSV	24b. Were a prior to death?	utopsy findings available completion of cause of	Э
ם י	in: In ificate or, pag	e Cor	Coronary 25. Was case referred	Arten	Disease				26 Place of De	1 ☐ Yes	2 No	1 ☐ Yes	2 No	_
<u> </u>	nysicie nis cert direct	To B	examiner?		Hospital: 1 Inpatie	ent 2 🗆 8	ER/Outpatier	it 3□ DOA	Ther	dome 5 ☐ Resi		□Other (Spe	ocify)	
	After th			Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	W	jury at /ork? □ Yes 2 □ No	28d. Describe	how injury	occurred		
DIVISION	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: Atlanthis certificate he completely filled in by the funeral director, page	Certification:	2 ☐ Accident 3 ☐ Suicide 6 4 ☐ Homicide	investigation Could not be determined	28e. Place of Injuding, et	ury - At hor c. (Specify	me, farm, str			28f. Location (City or To	Street and wn, State)	Number or R	ural Route Number,	
	e Hospita 124 hours e Funerai letely filled	Medical C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best liner: On the basis of and manner sta	examinati	vledge, death ion and/or in	n occurred at the vestigation, in my	time, date and place y opinion, death occ	e, and due to the urred at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)	
	vithir To th comp	Me	29b. Signature and title	of certifier				29c. Lice	nse number		29d. Date	signed (Mon	th, Day, Year)	
	1/1		MA	y t	- , M	D	22a) (T :	Deleth	-000		April	13, 2	005	
2	11		30. Name and address	Kuc	eompleted cause of d	na i	OS DI	tal o	F Baltimo	re				
	Sta Registr		31. Date filed (Month, I	Day, Year) APR 1	MD Single 1997 Sin	s Signat	ure &	Sparke)					

_			1 - For State Registrar	State of		nd / Dep		of He	alth a		lental Hy		9 ibie. 0 5	13039
	Dhysia	ion	Decedent's Name (First, Middle,	Last)			41				2. Date of De		Year	3. Time of Death
	Physic /Medi		Margaret				Ah	rev	15		April	Pay 13	2005	2:30 PM
	Exami	ner	4a. Facility Name (If not institution,			- (4b. City, To					4c. Cou	nty of Death	
			Johns Hopkins	30yview m	docal	Center	Ba	14,	MC	we	-			
	Funeral			. Sex 7. 1 ☐ M 2 🔀 F		last birthday) Yrs.		Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th i <i>y, Year)</i>	9. Birthp Cour	lace (State or Foreign
	Director		176-01-3622 Usual Residence of Decedent		93	113.					Nov 10	, 1911	P	4
	ehow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	aftar daath with tha Maryle or Itame 23a or 28e-1 ehor mirar mual be rottilled at	ğ	PA York		7	York								1 ☐ Yes 2 ▼No
	or 286-f	Funeral Director	10e. Street and Number				10f. Zip Co	ode				10g. Citizen	of What Coun	itry?
	th witi	<u>=</u>	1748 Normandie D	rive			174	04				USA		
	daa	ner	11. Marital Status	12. Was Decede	ent Ever in U	I.S. 13.	Was Deceden	t of Hisp	anic Orig	gin? (Spe	cify Yes or No Rican, etc.)		lace - Americ	
ဖွ	or its	교	1 Never Married 2 Married		Mo No		_			, Puerto i	Hican, etc.)		llack, White,	etc.
8	ours ref.,	d by	3 ☑ Widowed 4 □ Divorced	Year or Date	s:		1□Yes 2∑	1 NO	Specify:			Spe	^{cify:} whi	te
5	iliad within 72 hours after death with the Meryland Hyglane. ther than "neturel", or Iteme 23a or 28e-1 ehow int, the Medical Exeminal must be notified at	Be Completed	15. Decedent's (Specify only highest of			16a. Dece	dent's Usual C kind of work of DO NOT use r	occupatione du	on ring most	of working	na	16b. Kind of	Business/Ind	dustry
121	Althin Par	ם	Elementary/Secondary (0-12)	College (1-4	or 5+)			retired)			.3			
2	be filad withing tall Hygiana.	ပိ	17. Father's Name (First, Middle, La	-41		Lat	orer	1.					acturi	ng
Maryland 21215-0036	2 should be filad withir and Mantal Hygiana. ie markad other than aumatic event, the Man	Be		ST)				1			(First, Middle, Gross		ame)	
₹	d Mar nark	ို	John F. Knaub			T								
Ma	d 2 should th and Mar 7 ie marke traumatic		19a. Informant's Name/Relationship			1					Route Numbe			Code)
	a m m		Robert L. Ahrens 20a. Method of Disposition	- SOII	20h F	IOL9			ו ער ו		York,		404	
Baltimore,	or o		1 Burial 2 ☐ Cremation 3	☐Removal from Sta	10	emetery, crer	natory or other	r place)					n - City or To	wn, State
Ē	rtmar rtant		`4 Donation 5 Other (Spec		MOL	int Ros					/2005	York	, PA	
Ba	parmit. Pagas Dapartment of t Important: If ite eny injury or of		21. Signature of Funeral Service Lic	l	M00986	5 Di		nera Maj	al Ho In Si	ome treet	Mt.		PA 17	347
8760,	Physician /Medical Examiner physician and physician and physician and the purisi-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (or c.	as a consequence as a c	uence of):		ody	hi		e Asi		on	O minutes
P.O. Box 6	death cariffic a attending p id for usa as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moptis? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	Ectopic pregn					1	Pate of deliver	y Day Year
Records, F	Tha iaw raquiras that tha ata has baan signad by th paga 2 should ba datacha	à	Part II. Other significant conditions	contributing to death	but not resi	ulting in the ur	derlying cause	e given i	in Part I.			bacco use co es 2□No		cause of death?
3eco	alawra hasbae la 2 sho	Completed					_				24a. Was autop	Sy	prior to com	sy findings available
B	icata cata										perfor 1 ☐ Yes	2 No	death? 1 ☐ Yes	2□ No
N N	icier cartif actor	Be	25. Was case referred to medical examiner?	Hospital:				04			(Check only o			
ot	Phys this ai dir	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Linpa		ER/Outpatient					e 5 Resid			
5	Jing Aftar funer	5	1 □ Matural 5 □ Pending	100	Day Year)	28b. Time of Injury		Injury at Work?	. /		3d. Describe h			6:00
S	daath daath stor: 'tha	Cat	2 Accident investigati 3 Suicide 6 Could not	be on Discoul	2005		T		2ØN		Victim	1	ousl.	tire
Division of Vital	or A aftar Direct in by	Certification;	4 ☐ Homicide determine	28e. Place of I building,	etc. <i>(Specify</i>	me, farm, stre	et, tactory, off	fice		14-	City or Tow	n, State)	ber of Rural	Route Number,
	pitai ours e orai fillad		29a, Certifier 1FT Certifying P	harinian Tarka ka	A - 6 mm - 1 - m -	10	me				1487W	man	ratie D	we
	To the Hospital or Attending Physicien: Tha law within 24 hours aftar daath. To the Funeral Director: Aftar this cartificata has complataly filled in by the funeral director, page 2.	Medical	one) 2 Medical Exa	thysician: To the bearing: On the basis and manner	of examinat	wiedge, death tion and/or inv	estigation, in n	my opini	on, death	place, ar occurred	d at the time, o	ause(s) and materials	nanner as sta , and due to t	ted. the cause(s)
\	To T	2	29b. Signature and title of certifier	ei				cense nu		C	2	29d. Date sign	. ~	ay, Year)
,	11	-	30. Name and address of person who	completed cause of	death (Item	23a) (Type 5					/	14 /	13	200
	U'			eiss 600	Nor	the wo	ite St	æ	f, B	Salfi	more	MD	212	87
	Sta	5	31. Date filed (Month, Day, Year)		trar Signat	ture	Some	W						
8	Registr	ir	APR	1 6 200	Malin	and the	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 🕽 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death +SUMCARINE SCHARD 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death MUSPITTAL Morcy MD UDMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days Months Hours 1**X**M 2□ F 216-52-2286 56 Vrs June MD. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Dundalk 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7522 Rabon Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Maryland Highway Elementary/Secondary (0-12) College (1-4or 5+) 10 years Maintenance Worker Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick N. Bumgarner Jr. Rita M. Hug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rita Bumgarner 7522 Rabon Avenue, Dundalk, Md. 21222 mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 15. 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2005 Baltimore City, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. -7110 Sollers Point Road, Dundalk, MD. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease of shock, or heart failure. Lis interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VASCULAR INFECTION Due to (of as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ASCULAR 1 Yes 2 No 3 Probably 4 Unknown FECTSON. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 1 Tes 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3FT DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner certificate be execu Box 68760. attending physician as the jo P.O. the detached signed by Division of Vital Records, pe has To the Hospital or Attending Physician: this After thours after death.

Cuneral Director: After the furtile of the fu To the Chours of To the Funeral Dir

Physiclan/Medical IF FEMALE: 23b. Was decedent pregnant 1 ☐ Yes 2 ☐ No 9 Unknown à Completed Be P Medical Certification: 3 Suicide 4 T Homicide 29a. Certifier (Check only one)

Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

10a, State

MD.

Funeral

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be partitled at

al Hygiene. I other than "

. Pages 1 and 2 should be fit timent of Health and Mental H tent: If item 27 is marked ott

6

permit.
Departr
Importa

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

25. Was case referred to medical examinar?
1 → es 2 □ No
27. Manner of Death
1 ☐Natural 5 ☐ Pending
2 ☐ Accident investigat

6 ☐ Could not be determined

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTSMORE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier

29d. Date signed (Month, Day, Year)

MD 2120

30. Name and address of person

ompleted cause of death (Item 23a) (Type, Print) 108

31. Date filed (Month, Day, Year) 1 8 2005

istrar's Signature 32. R

State

Registra

			1 - For State Registrar	State of Mar		artment of H		ınd Me	_	giene Reg. No.	005	13041
	0		1. Decedent's Name (First, Middle,					2.	Date of De	ath		3. Time of Death
	Physic /Medi		PHILLIP J.	BOWER				1	A Dn	I Oay	2005	4:46 AM
	Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of	f Death		4c.	County of Death	
	Funeral			1001	(In yrs. last birthday)		If Under 2		Date of Bir	th		lace (State or Foreign
L	Director		218-46-5226	1 M 2 □ F	58 Yrs.	Months Days	Hours	Min.	Date of Bir (Month, Da larch	13,1	947 Mar	yland
	D .		Usual Residence of Decedent									
	aryla ehov	-	Maryland Anne	Arundel	10c. City, Town or Lo		.1.				10	0d. Inside City Limits 1 ☐ Yes 2 🗹 No
	Ne M	ecto	10e. Street and Number	Alunder	DI(ooklyn Pai	K					
	with t	ä				10f. Zip Code				10g. Citiz	zen of What Coun	try?
	eath	erai	11 Nann Avenue	12. Was Decedent Ev	ver in IIS 12		225	in? /Specifi	v Vac as No		U.S.A.	an Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, it e Modical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Specify:	, Puerto Ric	an, etc.)		Black, White, e	etc.
21215-0036	2 hou	ed	15. Decedent's	l	16a, Dece	dent's Usual Occupa	ation			16b Kin	nd of Business/Inc	
215	within 7. ene. then "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired	luring most)	of working				,
2	filed withii Hygiene. other then ent, Ire M	On	12	O		at Cutter	•			Ţ	Weiss Ma	rket
D	al Hy d oth	Be (17. Father's Name (First, Middle, La	•				's Name (F	irst, Middle,			
Maryland	should be ind Mental I marked or	ဂ္	Phillip H.	Bower			Zio	landa	L	aRoss	sa	
lar	2 sho		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a	ınd Number	ror Rural R	oute Numbe	er, City or	Town, State, Zip	Code)
	1 and 2 Health tem 27		Madge Duncan	(Daughter)	3 Bo	ulevard I	lace,	Lint	hicum	, Mar	ryland 2	1090
Baltimore,	@ O == ==		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	☐Removal from State	· - ·	matory or other plac	· 1	Date			cation - City or To	
Ë			'4 □Donation 5 □Other (Spe		_	Crematory	,	4-14-	P		imore, Ma	aryland
Ba	permit. Departr Importe any inje		21. Signature of Fineral Service Lie	Kam		2. Name and Addres CCully-Pc 37 East F	acabs	CO AV	e. ba.	T E I Ma	P.A. ore. Mary	vland 2122
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the ly one cause on each line.	ne death. Do not ent	er the mode of dying	g, such as c	ardiac or re	spiratory ar	rest,	6.5	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a BRAIN	V TUM	DA					6	Onset and Death Wowllis
	/Medical Examiner		resulting in death)		consequence of):							
Н	LAGITITICI	Ļ	Sequentially list conditions, if any, leading to immediate		IONIA							2 days
	led Isit	niner	cause (Disease or injury		consequence of):	0						2 days
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a c	RE PI	KATORT	fet.	LUP				2 days
8760,	siciar buri	dicai E										
89	ificate g phys as the	edic		0.								
Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		7				23	3d. Date of deliver	ry
m	death e atte	icia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin		Ectopic pregnancy Other (specify)				1		Day Year
P.O.	at the de by the a tached	hys	9 Unknown	9□ Unknown								
	signed to the det	by F	Part II. Other significant conditions			nderlying cause give	n in Part I.		23e. Did to	bacco us	e contribute to the	e cause of death?
Division of Vital Records,	w requir been si should l		SE	ZURE DISO	RDER			1	1 🗆 Y	′es 2 🗆	No 3 ☐ Proba	ibly 4 Winknown
ပို	e lawr has be je 2 sh	Completed	AST	HMA					24a. Was autop		24b. Were autop	sy findings available
<u>~</u>	ate pag	Con							perfor	med? 2 X No	death?	2 M No
/ita	Physicien: The this certificate al director, pag	Be (25. Was case referred to medical examiner?				26. Place o	of Death (C	heck only o			
	S 0 T	유	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	r: 4 ☐ Nurs	sing Home	5 🗆 Resid	ence 6	Other (Specify))
n o	ffer len	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Work	?		Describe h	ow injury	occurred	
200	Attending or death. ector: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	he			es 2 □N					
\leq	or A after Direction by	Certification:	4 ☐ Homicide determine	building, etc. (- At home, farm, str 'Specify)	eet, factory, office		281.	City or Tow	n, State)	Number or Rural	Route Number,
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physicien: To the best of reminer: On the basis of ex	ny knowledge, death	occurred at the tim	e, date and	place, and	due to the o	ause(s) a	and manner as sta	ited.
	To the within 24 To the F Complete	Med	one)	and manner stated	d.	00= 11===	.,			and and h		
	7 wit	-	29b. Signature and title of certifier	LO MA		29C. License	number	(0)10	, 2	29d. Date	signed (Month, D	ay, Year)
			7 1110 008	WY (11 D		brig	rt Pl	3718		TIPY	11 10, 2	005
2	1		30. Name and address of person wh	o completed cause of deat	th (Item 23a) (Type,	Print)		ULAKA	. 6~	- 4	BALTIMO	OREI
5	Ct-	to	29b. Signature and title of certifier MOCOS 30. Name and address of person wh MILENA A. GEN 31. Date filed (Month, Day, Year) APR 1 8 2	32#Registrar's	Signature	PICAL, SO	01 2	סעראגדו	VEK 1	1,	MD, 21	225
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ORIGINAL

Amend item 26 per/physics 247 4 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} **Physician** Month Eileen Barker April 2005 4:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 452 N. Clinton Street Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Funeral Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2XF 217-28-9634 Yrs. Director 73 4/16/31 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore MD Director 1 ☐ Yes 2√2 No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2905 Dunbrin Rd. , Apt.B 21222 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Xidowed 4 Divorced Specify: White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Brown Florence McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau Melody Finnerty-daughter 6718 Boston Ave., Balto., MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4/8/05 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of by ing such a carsap of rish gory and shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Obstructive Physician Chronic disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Enter or certaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? heart 1d es 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed?

1 Yes 2 No certificate Jease di 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Special DOE) 1 Yes 2 No 2 filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral (
completely filled To the Hospital 29a. Certifier 🔁 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabrey Mc Sastem egistrar's Signature 31. Date filed (Mon 2005

State Registrar

			for State	-		/ Depa	artment of H	lealth a		•		005	13043
			1 - State Registrar	f 41		Cei	rtificate of l	Death			eg. No.		
	Physici	an	Decedent's Name (First, Middle,	Last)					1	Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Theodore		Μ.			ielski		April	14	200	3.55 PM
	Examin	er	4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or		f Death	1	4c. C	county of Death	1
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П	Funeral		,	5. Sex 7. Ag 1 1 M 2 □ F	e (In yrs. las	St Dirthday) Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day,	Year)	1	nplace (State or Foreign untry)
١.	Director		217-34-9779 Usual Residence of Decedent		_67					Dec. 20	193	37∟Mar	yland
	land		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Hary Fish	ō	Marvland Anne	Arundel	Pas	adena							1 ☐ Yes 2 ☐ No
	28e	Director	10e. Street and Number		1 45	ducine	10f. Zip Code			1	0g. Citize	en of What Cor	untry?
	3a of		15 Little Lane				21122						
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	21122 Was Decedent of H f Yes, specify Cuba	ispanic Orig	in? (Spec	ify Yes or No-		I.S.A 4. Race - Amer	
0	or He	Ē	1 Never Married 2 Marrie	Armed Forces? d 1 → 7es 2 □ 1	No	1			Puerto R	ican, etc.)		Black, White	, etc.
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21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "netural", or Hems 23a or 28e-1 show event. The Medical Evantrair neat be notified at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occup- kind of work done	ation	of working	2	16b. Kin	d of Business/I	ndustry
7	filed within 72 Hygiene. other than "nei ent, 'ne Medic	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retired	1)					
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<u>X</u>		2	Adam		Biel	ski		Ste1	la_			Kucl	htiak
Maryland	2 2 3	10	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street a	and Number	r or Rural	Route Number	City or	Town, State, Z	ip Code)
	1 and 1 Health em 27		Christopher M.	<u>Bielski (Sc</u>		15 L	ittle Lar	ne Pas					
ore	es 1 a of Hea If Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	∃ □Removal from State			sition (Name of natory or other place		Da		20c. Loc	ation - City or 1	Town, State
altimore,	Pages ment of ent: If It ury or o		' 4 ☐ Donation 5 ☐ Other (Spe		Gle	n Hav	en Mem. I	2k. ↓4	19/	05	G1en	Burni	e, Maryland
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	/Medical		resulting in death)	Due to (or as	a conseque	nce of):	ACOUNT OF				()	9
L	Examiner		Sequentially list conditions	b									
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Š	death certifical attending phy d for use as th	Physician/Med	IF FEMALE:	00-14	-4					Y			
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	ding Phys h. After this funeral dir	Certification:	27. Manner of Peath 1 XNatural 5 ☐ Pending		y Yea <i>r)</i> 2	8b. Time of Injury	Worl			ld. Describe ho	w injury	occurred	
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E.	Physician: To the best of xaminer: On the basis of and manner sta	f examinatio	n and/or in	vestigation, in my of	ne, date and pinion, death	h occurred	d at the time, da	ate and p	nd manner as lace, and due	stated. to the cause(s)
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Theodore

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Fune	ral			. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Rin	hplace (State or Foreign
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ırylar	1	.	10a. State 10b. County			ty, Town or Lo			3		10d. Inside City Limits
Ba-f		5	Maryland	Baltimo	re			rt Howar			1 ☐ Yes 2½ No
vith th		Director	10e. Street and Number				10f. Zip Code		109	g. Citizen of What Co	ountry?
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er de Itam		ň	 Marital Status 1 XNever Married 2 Married 	Armed F		1.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	14. Race - Ame Black, White	
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Vialing Suld be fill Mental Hy arked oth		0	William H. Bu	schman,	Jr.			Bai	rbara J. 1	Ross	
and and is my			19a. Informant's Name/Relationship							City or Town, State, 2	
1 and Health em 27		-	Mrs. Barbara	Buschi					Howard, I		21052
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requires that the een signed by the	5	by P	Part II. Other significant condition	- T	death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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on or of ding Phys	5		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mo	of Injury onth, Day Year)	28b. Time o	Wor	k?	28d. Describe how	injury occurred	
VISION Attending or death. rector: After		cati	2 ☐ Accident investiga				M 1 🗀	Yes 2 □ No			
or Att	n n	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 280. Plac	ce of Injury - At h ding, etc. (Speci		reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
spitel	Dalli		29a. Certifier Certifying	Physician: To the	ne best of my kn	owledge, deal	h occurred at the tii	me, date and place	, and due to the cau	ise(s) and manner as	s stated.
To the Hospitel or Attending within 24 hours after death.	npieldu	Medical	one)	and ma	nner stated.		22. 1			e and place, and due	
ST # ST	3		29b. Signature and title of certifier	1//01	Macro		29c. Licens	1830L	290	d. Date signed (Mont	Day, Year)
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	0		30. Name and address of person w	CA C	use of death (Ite	m 23a) (Type, 40 C	East	ern Bl	vd. Be	altimos	~ MD
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Reg	gistra		31. Date filed (Month, Day, Year) APR 1 8 200	O JESTINE	1	No. of Street, or other Persons					

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		1	For State Registrar	State of Maryla		rtment of He tificate of L			gien <u>e</u> U U Nog. No.	0 10040
	Physicia		Decedent's Name (First, Middle, La	st) D	200			2. Date of Dea	Day Y	3. Time of Death
	Physicia /Medic	al -	4a. Facility Name (If not institution, giv	a street and number)	OER	4b. City, Fown or	Location of Death	Horit	4c. County of	005 4:20 AM
	Examin	er	Good Spr	ra Ritan Nu	isne Cta	5	altic	nove		
	Funeral Director		250-44-51/2	Sex 7. Age (In yrs	yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 09-28-1	929 S	Birthplace (Stete or Foreign Country) South Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City Limits
	a-feh	ctor	Maryland n/a		Baltimore					1 ∑ Yes 2 □ No
	with the	Dire	10e. Street and Number 1601 E. Belvedere Av	onuo Baltimoro M	lary] and	10f. Zip Code 21239			10g. Citizen of Wh	nat Country?
	ms 23	nerai	11. Marital Status				ispanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No-		- American Indian, White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important; if Item 27 is marked other than "natural" or 200.000. In Maryland I Franch for must be multiped at 000.000.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 【VX No If Yes, Give Year or Dates:		Yes 2XXNo	Specify:	Though, Occ.y	Specify:	Black
2-0	"natur	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Deced (Give I	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work ()	ing	16b. Kind of Bus	iness/Industry
72	fited within Hygiene. ther then ent, the Ma	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 2 MS.		iatric Nurs			Nursing Ho	ome
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Maryland	i Mental narkad c	Jo	James Bruce 19a. Informant's Name/Relationship	(Tuna Brint)	19h Mailin	a Address (Street	Rebecca Bi		ar. City or Town, S	itate, Zip Code)
Ma	nd 2 sho lith and 27 is ma		Gerald Brown/Son	(Typa, Frint)			d, Randalls			
Jre,	es 1 and 2 of Health of Hem 27 I		20a. Method of Disposition 1 Disposition 2 Cremation 3		. Place of Dispos	sition (Name of natory or other place		Date	20c. Location - C	City or Town, State
Baltimore,	Pages Iment of I tant: If It jury or o		*4 □ Donation 5 □ Other (Spec	ify) Ba	iltimore N			9-05		, Maryland A. of Baltimore Co.
Balt	permit. Pages Department of Important: If It any injury or once.		21. Signature Funeral Service Lice	11/11/1/1/	920	00 Liberty I	Road, Randa	llstown,	MD 21133	
			23a. Part . Enter the disease, or cor shock, or heart failure. List ont	nplications the caused the de y one caused in each line.	eath. Do not enti	er the mode of dyin	ig, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 1 9 Due (0)	equence of):	perall	000 10	nellie	Trusc	
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	xecute and al-tran	Examine	that initiated events resulting in death) Last	C Due to (or as a cons	equence of):					V
8760,	cate be executed physician and the burial-transit	dical		d						
Θ	entifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pred	onancy				23d Date	of delivery
.O. Box	it the death certifii by the attending partached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3[Ectopic pregnancy Other (specify)	<i>y</i>		Mon	
<u>α</u>	luires that n signed by	by	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.			bute to the cause of death? 3 Probably 4 Dunknown
Records,	The law requires that the death certifiate has been signed by the attending page 2 should be detached for use as	Completed						24a. Was auto perfe 1 \(\text{Yes} \)	psy ormed? de	Vere autopsy findings available rior to completion of cause of eath?
Vital		Bec	25. Was case referred to medical examiner?	Hamitali		0**	26. Place of Dea			//
of\	ys diib	. To	1 Yes 2 No	28a. Date of Injury	28b. Time o	nt 3 DOA	4 Alnursing H		idence 6 Othe	
ion	Attending Ph sr death. ector: Atter th by the funeral	ation	1 Natural 5 Pending Accident investigat	(Month, Day Year ion) Injury		rk?]Yes 2□No			
Division	To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification:	3 Suicide 6 Could not determine		t home, farm, st.	reet, factory, office		28f. Location City or To	(Street and Number wn, State)	er or Rural Route Number,
	Fo the Hospitel or within 24 hours afte Fo the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my arniner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	th occurred at the travestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) and mar , date and place, a	nner as stated. and due to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	K. Tarpe	waev	29c. Licen.	30661		April	13th 2005
	4		30. Name and address of person who 5601 Lo Ch	Kaven	Blyd	, Bal	timo	e, 4	d-2	1239
	Si Regis	ate trar	31. Date filed App Day, Year 2	95. Registrar's Si	gnature	W				

State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death APRIL 13, **Physician** VIOLA ALBERTA BACKUS 2005 8:15 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death . Facility Name (If not institution, give street and number)
FUTURE CARE OLD COURT ROAD Examiner BALTIMORE RANDALLSTOWN 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 95 vrs If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, APKIL 5. Social Security Number 241 16 1693 **Funeral** 6. Sex Months Days Hours Min 1□M 🎾 F N.C. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location BALTIMORE 10b. County 10d. Inside City Lignits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exactiver must be notilised at BALTIMORE MD. 1 Yes 2 No Director 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? death with 2911 DUPONT AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I proportant: If item 27 is marked other than "natural", or fler any injury or other traumatic event Black, White, etc. Specify: BLACK 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 → Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)
UNKNOWN SEAMSTRESS SELF EMPLOYED 17. Father's Name (First, Middle, Last)
WILLIAM THOMAS WINSLOW 18. Mother's Name (First, Middle, Maiden Sumame) ELEANORA PERRY DAUGHTER Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Right) SOPHRONTA B. JONES 2911 DUPONT AVENUE BALTO.,MD. 21215 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State PARK CEM. 4/19/05 BARTIMORE, MARYLAND LOUDON * 4 ☐ Donation 5 ☐ Other (Specify) LEWIS and Address Of Friend FUNERAL HOME 21215-6393 21. Signature of Funeral Service Liden Per IS T. GWYNN 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO., MD. 4517 PARK HEIGHTS AVENUE Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CORONAR ARTER DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown OEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes nt or Attending Physician; after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Diractor: After this
filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K.S.RAC.MID. APRIL 15 2005 0 43462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 C . S . RAC . M.O. RAHDALLSTOWN 5400 old count nd # 108 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar APR 1 8 2005

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crn		1 - For State Unpe	end Ite	m 23a,	27 , 28	a-f pe	er mee	illeate	4-28	Death	as	Ciliaiii	Rag. No	20	05	131	047
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/Medic Examin		4a. Facility Name (If	f not institution	-	and numbe	r)		4b. City,		r Location o	of Death	April		County o	005 f Death	5:35	_P
		2525 E. 5. Social Security No.		an Stre		an /In vrs	ast birthday)	Ba.	ltim		24 Hrs.	8. Date of B	irth	N/A		ace (State of	r Foreign
Funeral Director		220-80-32	253	1 X M 2		44	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D	ау, Year 3 — 60)	Count	ace (State or ry) Md.	· orongin
/land		Usual Residence of 10a. State	Decedent 10b. County			10c. City	/, Town or Lo	cation							10	d. Inside Cit	y Limits
Se-fsh	ector	Md.		NA			Ba	ltimo								X □Yes	2 🗌 No
inc, with y railed within 72 hours after death with the Maryland at and Aenhal Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, in a Madical Examinar must be notified at	by Funeral Director	10e. Street and Nun 8633 Tr		.11 Rc	l.				2123				Ţ	itizen of Wi	nat Count	iry?	
tter dea	Fune	11. Marital Status 1 ☑ Never Marrie	ied 2∏ Mar	ned 1.	med Force: □Yes 217	T No.	S. 13. 1	Was Deced If Yes, spec	lent of H offy Cuba	lispanic Orig an, Mexican	gin? (Spe , Puerto I	cify Yes or N Rican, etc.)	0-	14. Race Black	- America , White, e		
ural', o		3 🗆 Widowed	4 Divorced	Ye	res, Give ear or Dates	S:		1 🗌 Yes :		Specify:				Specify:	Bla		
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Id ba fii ental H ked ott	To Be	17. Father's Name (Irving	(First, Middle,	Last)		В	rown,	Jr.			rs Name nirle	(First, Middle Y	e, Maidei) ellir	ngs	
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parmit. Pages 1 and 2 Department of Health Importent: If Item 27 i any injury or other tra		Eness Br	position		Siste	20b. P	lace of Dispo	sition (Nan	ne of			, Balt	,	ocation - C		21239 wn, State	
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parmit. Pages Department of Importent: If II any injury or o	ć ,	21. Signature of Fu	neral Service	Licensee	112					ss of Facility	·	1101				1. 212	02
		23a. Part1. Enter the shock, or hear	he disease, o	complication	s that caus	ed the death								OLCII	Ave.	Approximate Interval Betw	een
Pnysician /Medical		Immediate Cause (disease or condition resulting in death)	(Final	a. Mi	xed A	1coho	1 and	Drug(Mor	phine)	into	xicati	on			Onset and D	eath
Examiner			47. *	b	Due to (or a	as a consequ	uence of):										
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ysiclen: The is certificate director, pag	o Be	25. Was case reference examiner?		Hospita	al: 1 🗆 Inpa	itient 2 🗆	ER/Outpatier	nt 3 DC)A Oth	05		<i>(Check only</i> ne 5 ☐ Res		6 XOther	(Specify	at s	cene
To the Hospital or Attending Physicien: The lwithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation; T	27. Manner of Death 1 Natural 2 Accident	5 Pendi invest	ng Fo	a. Date of Ir Dund: 1	njury Day Yeer)	Found:	р М	8c. Injun Worl		i i	8d. Describe				200000000000000000000000000000000000000	
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Hospit 24 hour Funers	Medical (29a. Certifier (Check only one)	1☐ Certifyi 2XMedica	ng Physician Examiner: O	: To the be on the basis	of examina	wiedge, deat tion and/or in	h occurred vestigation.	at the tin	me, date and ppinion, deat	d place, a	ind due to the	a cause(s	s) and man	ner as sta	ated.	
To the within 7	Me	29b. Signature and	title of certifi	1	\overline{n}	1		290		e number			29d. Da	ate signed	(Month, E	Pey, Year)	
		W.	10	Hex	n	1				CME			Apr	ril 06	, 20	005	
		30. Name and addre	ess of person	who completed	ed cause o	t death (Item	1 23а) (Туре,		1 Pe	enn St	reet	Balt	imor	e, Ma	aryla	ınd 212	201
Sta Registi		31. Date filed (Mon		8 2005	32. F gi	strar's Signa	ture	book	,								

DHMH 17 Rev 1/2001

ORIGINAL

		1	For Amend Item	23a,Pt1,	f Maryla I I per	nd / Dep	atment/9f8/ rtificate of i	osthand Death	Mental Hy	giene20	05	13048
			Decedent's Name (First, Middle	e, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		Tr	ene Lucil	le Beni	nett					2005	5 12:50A M
	Examin		4a. Facility Name (If not institution			1	4b. City, Town, or			4c. County		
			Saint Josep				K Hadas & Vans	If Under 24 Hr.				imore
	Funeral Director		5. Social Security Number 412-03-3470	6. Sex 1 □ M 2√□ F	7. Age (In yr.	s. last birthday) Yrs.	Months Days	Hours Mir	(Month, Da	, 1917	Cot	nplace (State or Foreign untry) INESSEE
		-	Usual Residence of Decedent						000. 7	, 1017	101	
	yiand	. [10a. State 10b. County		10c. (City, Town or Lo	ocation					10d. Inside City Limits
	e Ma	cto	Maryland Balt	imore		Towso	n					1 Tes 2 No
	라 다 S O S S S S S S S S S S S S S S S S S	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of		
	ath v	E .	305 E. Joppa R			11.6	2128		Canada Van er Ne	United		ican Indian,
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. And Health and Mental Hygiene. Or other traumatic event, the Modical Examinar must be notified at or other traumatic event.	Funeral Director	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. was Dec Armed F	edent Ever in orces?	0.5.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (in, Mexican, Pue	rto Rican, etc.)	Bla	ck, White	
2	urs af	þ	3 ☐ Widowed 4 ☒ Divorced	If Yes. G	ive Dates:		1 ☐ Yes 2 XNo	Specify:		Specif	y: Wh	nite
5	2 ho	Completed	15. Deceden	t's Education	1		dent's Usual Occup		orkina	16b. Kind of B	usiness/l	ndustry
	within 7 iene. than "r	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	d)	J. Mily			
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5	should nd Men marke umartic	2	James 19a. Informant's Name/Relations	thip (Type, Print)			ng Address (Street			er, City or Town		
Z Z	od 2 sho Ith and 27 is m		David R. Pulli				St. Franc			•		
ē,	tem 27 other tra		20a. Method of Disposition		- 1	Place of Disp	osition (Name of matory or other place	1	Date	20c. Location		
Ē	Pages ent of nt: If ii		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		State		Crematory	.	2, 2005	Baltin	nore,	Maryland
Baltimor	permit. Page Department o important: If any injury or once.		21. Signature of Funeral Service	Licensee		an T. Ĉ		ss of Facility uneral	Services			Valley, P.A
	Physician		23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	each line.	eath. Do not en	ter the mode of dyin	ig, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to	(or as a cons	equence of):						
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	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	c. Due to	(or as a cons	equence of):						
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O. Box	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live	utcome of preg birth 2 Fe Inant at time o nown	etal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	,			ate of deli	very Day Year
rds, P	w requires that the death been signed by the atte should be detached for	by	Part II. Other significant conditi Chronic Atrial	ons contributing to Fibrilla	death but not r	esulting in the C ith Rap	id ventri	en in Part I. Cular esponse		tobacco use con		the cause of death?
Vital Records,	rsician: The law re s certilicate has bee lirector, page 2 sho	Completed	Acute Abdomen	with Leuk	ocytos:	is, Cor	onary Art	ery	24a. Was auto perf 1 Yes		Were au prior to death?	topsy findings available completion of cause of
IIa	ysician: is certific director,	Be (25. Was case referred to medica examiner?	16.1					eath (Check only	one)		
0	Physic this co	ျှ	1 ☐ Yes 2 No			☐ ER/Outpatie		4 Iduising	Home 5 Res			cify)
	ding Ph h. After th funeral	inol :	27. Manner of □eath 1 □ Natural 5 □ Pendi	ig .	of Injury nth, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊟No	28d. Describe	how injury occu	rred	
<u>s</u>	Attendi death. ctor: A y the fu	Icat	2 Accident investi	not be 290 Place	e of Injury - At	thome farm st	reet, factory, office	162 2 140	28f. Location	(Street and Num	ber or Ru	ıral Route Number,
Division	l or A after Direction by	Certification;	4 ☐ Homicide determ	nined 200. Flat	ding, etc. (Spe	cify)	reet, lactory, office		City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours alter dealh. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Certifying	ng Physician: To th Examiner: On the and ma	ne best of my k basis of exam nner stated.	rnowledge, dea ination and/or in	th occurred at the timestigation, in my o	ne, date and place pinion, death oc	ce, and due to the curred at the time	cause(s) and m	anner as , and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	er /	7		29c. Licens	e number		29d. Date signe	ed (Month	h, Day, Year)
			(O Virolla	my			D Ø	Ø25886		april	/	14 2005
3	7		30. Name and address of person	who complete car	use of death (I	tem 23a) (Type				-		
9			LILIA CEBAL	LOS MaDa	7601	OSLEE	DRIVE	HOSWOT	MARYLA	ND 212	214	
	Sta Registr		APR 1	2005	Registrar's Sig	gnajure	or in					

## # Facility Name of first antificion; price steers and numbers 4c. Courne of Dearn 4c. Courne 4c. C			1 - For Unpend Item Registrar 1. Decedent's Name (First, Middle, La			-				2. Date of De	aath		3. Time o	f Death
## Facility Remote Facility			Dean Cumbie										9:290)!
Social Service The Principle of Principl			4a. Facility Name (If not institution, give	e street and numbe	er)		4b. City, Tow	n, or Locat	ion of Death		4c. C	ounty of Dea	h	
Usas Residence of Decedered 10. Sale 90. County 10. City Town or Lossition 10. City Town or Lossition 10. City Town or Lossition 10. Cookswille 10. City Town or Lossition 10. Cookswille 10. City Town or Lossition 10. City Town or Lossition 10. Cookswille 10. City Town or Lossition 10. City Code 11. Means Status 11. M									dos 84 Uso					
The Sale 100 Courty 100 College 100 Co										(Month, Da	ay, Year)		hplace (State ountry)	or Forg
19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Stress and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201 20a Method of Deposition 1 20m 2 2 2 2 2 2 2 2 2	M H	}			10c. City,	, Town or Lo	cation						10d. Inside C	ity Limi
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The part of the pa	r mus	nera		12. Was Decede	ent Ever in U.S	S. 13. V	Was Decedent	of Hispanio	Origin? (Spe	cify Yes or No)- 14	1. Race - Ame	ncan Indian,	
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	To the compl	Me	29b. Signature and title of certifier Jashak	Siev	Q xi	D			per					
30. Name and address of person who completed cause of the 23a) (Type, Print) Tasha Z Greenberz MD 111 Penn Street Baltimore, Maryland 21			30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)							

	1	For Stele Registrar		State o	т ма	ryland /		rtmen tificate)		Reg. No	000		12	050
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/Medical Examiner		a. Facility Name (If not ins		treet and nu	mber)				Town, or	Location	of Death		40	c. County of Dea			
Funeral Director		. Social Security Number +96–56–3913	6. Sex	Iм 2□ у F	7. Age	(In yrs. last 45	birthday) Yrs.	If Under Months	1 Year		Min.	Date of Bir Month Da By 15	th 1959			e (State o	or Foreign
	-	Jsual Residence of Deced	County			10c. City, T	own or Lo	cation							10d	. Inside C	City Limits
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with the		10e. Street and Number	onbury	Шау				10f. Zip	Code 1014	+			10g. C	itizen of What C	ountry	?	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural; or Items 23a or 28a-f show aumatic event, the Medical Exercitar front be notified at To Be Completed by Funeral Director	5	11. Marital Status 1 Never Married 2 3 Widowed 4 Di	Married	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	rces? 2/1 No ve		ĺ	Vas Deced f Yes, spec		lispanic O an, Mexica Specifi		ify Yes or No ican, etc.)	>-	14. Race - Am Black, Wh Specify:	ite, etc	2.	
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lary 2 shou and M and M is man is man aumat		19a. Informant's Name/Re												or Town, State,		ode)	
2 5 € 5 £	0	Michael A. 20a. Method of Disposition	1			20b. Plac	e of Dispo	Li⊥as sition (Nar natory or c	ne of		Way, E	Bel Ai		1D 21 01 Location - City o		n, State	
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Colles falled H H Division of Vital Red Division of Vital Red Division of Vital Red To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	0	1 Yes 2 No 27. Manner of Death 1 Nonether Section 1	Pending investigation	28a. Date (Mo		nt 2□Ef ry y Year) 2	NOutpatie 8b. Time o Injury		28c. Inju Wo		2			6 M her (Si	oecify)	401	f10
Division of Division of Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this: completely filled in by the funeral director of the Funeral director.	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e, Plac	ce of Injuding, etc	ury - At hom c. (Specify)	e, farm, st	reet, factor				8f. Location City or To	(Street own, Sta	and Number or ate)	Rural	Route Nu	ımber,
DiCCD) Dio the Hospital or within 24 hours after on the Funeral Dir ompletely filled in	edical C	29a. Certifier (Check only 2 1 one)	Certifying Phy Medicel Exam	iner: On the	ne best basis of inner sta	f examinatio	edge, dea n and/or ir	th occurred	at the t	ime, date opinion, d	and place, a leath occurre	and due to the	e cause e, date a	e(s) and manner and place, and d	as sta	ted. the cause	e(s)
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State		31. Date filed (Month, Da	1 8 200	5 60	Registr	ar's Signatu	Te doe	Lis.									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death W. CARNEAL **Physician** April 14,2005 4:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6124 Medora Road Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Feb. 18, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 12 M 2□F 79 212-24-7853 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumstic svent, the Medical Exercit er must be notified at 1 Yes 2 No Linthicum Director Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21090 U.S.A. 6124 Medora Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. is marked other then "naturel", or Iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse 8 0 Sheet Metal Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eades Gertrude William Carneal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m eny injury or other treum once. Eleanor Carneal 6124 Medora Road, Linthicum, Maryland 21090 (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park 04-16-05 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltimore, us Maryland 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate In erval Between O set and D Immediate Cause (Final disease or condition resulting in death) Physician oslo /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown cate has been signated bage 2 should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 ☐Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 📉 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print) s of person who co 10 no 32 Registrar's Signa State 2005 18 Registrar

		1	State of Maryland		rtment of Hetificate of L			giene Reg. No.	2005	13052
			I. Decedent's Name (First, Middle, Last)				2. Date of De	ath	V	3. Time of Death
	Physicia		Rosalys Conners				Month April	Day 12. 2	Year	10:05 PMM
	/Medic		la. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death			ounty of Deat	th
	Examin	er	Blakehurst Retirement Community			Towson		Ba	ltimor	e
_			i. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bin (Month, Da			hplace (State or Foreign ountry)
	Funeral Director		178-12-5387 1□M 2\QF 86	Yrs.	Months Days	Hours Min.	09/02/	1918	мо	ountry)
		-	Jsual Residence of Decedent	1			0 3 / 0 = /			
	/land		10a. State 10b. County 10c. City,	Town or Lo	cation					10d. Inside City Limits
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	r 28a	e e	10e. Street and Number		10f. Zip Code			10g. Citize	n of What Co	ountry?
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	ms 2	era	11 Marital Status 12. Was Decedent Ever in U.S	i. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No	- 14	Race - Ame Black, Whit	
_	r Ite	표	1 Never Married 2 Married 1 To Yes 2 No		_ 🔻	Specify:	rticari, otc.)		anaihu	
3	urs a	þ	3 Widowed 4 □ Divorced If Yes, Give / Year or Dates:		Yes 2月No	Specify.		3	ipecify: Wh:	ite
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Ē	Pages nent of ant: If it		1 ☐ Burial 2 SCremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Che	esapea	ke Cremat			Belt	sville,	, Maryland
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>	ysici s cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 ursing Ho	me 5 🗆 Res	idence 6	□Other (Spe	ecify)
Division of Vital Records,	g Phys er this eral di	ä	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at	28d. Describe	how injury	occurred	
<u></u>	th: After	i i	1 ☑Natural 5 ☐ Pending (Month, Day Feat) 2 ☐ Accident investigation	injury		Yes 2 □ No				
/IS	Atter dea	fice	3 Suicide 6 Could not be	me, farm, st	reet, factory, office			Street and	Number or F	Bural Route Number,
á	after Dire	Certification:	4 Homicide building, etc. (Specify	′/			Only of 10	, 5.4.0)		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Compietely filled in by the funeral director, page 2 should be detached for use as the burial-transity.	alc	29a. Certifier 1 Certifying Physicien: To the best of my know	wledge, deat	h occurred at the tir	ne, date and place,	and due to the	cause(s) a	and manner a	s stated.
	e Ho 24 t e Ful letely	edical	(Check only one) 2 Medicel Exeminer: On the basis of examinal and manner stated.	tion and/or in	vestigation, in my o	pinion, death occur	red at the time	date and	piace, and du	e to the cause(s)
	To the within 2	2	29b. Signature and title of certifier		29c. Licens					th. Day, Year)
)			> MARCHY		D 30)433		THEM	L 15,.	2005
,	0		30. Name and address of person who completed cause of death (Item	1 23a) (Type.	Print)				. 1	21204
1	U		11 MM. 1. 1 / 16 MM / 1001 11	NILIAM	112 (7	ish	MORE	,	WW Z	4104
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Igna	ture	och si	,				
	Regist		APR 1 6 2005 Allene.	an A	" Gosta					

		-	For State Registrar			State	of Ma	arylan		artmen rtificate				ental Hyg	giene Reg. No	4 0 0 0	3	053
	Physici	an	Decedent's Name											2. Date of Dea	Da		-	of Death AM ^M
	/Medic Examin		Michael I 4a. Facility Name (II							4b. City,	Town, or	Location		April		2005 County of Dea		FAIN
			313 Morr	is Ave	nue								rvill			altimor		
	Funeral		5. Social Security N		6. Sex	M 2□F		e (In yrs. I 57	ast birthday Yrs.	Months	1 Year Days	If Under Hours	Min.	B. Date of Birt (Month, Da)	y, Year)	- 1	irthplace (State Country)	e or Foreign
	Director	-	217-50-7 (Usual Residence of			•		37						04/01/	1948	B VA		
	ryland how		10a. State	10b. County	/			10c. City	, Town or L	ocation							10d. Inside	City Limits
	8a-f	Funeral Director	MD	Balt	imore	<u> </u>		Lut	hervi	lle Ti		Lum			10: 0"			35 2 M 140
	with the	를 -	10e. Street and Nur							10f. Zip					_	izen of What C		
) I	ns 23	eral	313 Morri	s Ave				Ever in U.:	S. 13.	Was Deced		ispanic Ori	igin? (Spec	ify Yes or No- ican, etc.)		ted Sta 14. Race - Am	erican Indian,	
9	after o	Fun	1 Never Marri	ed 2 Ma	rried		Forces?	No		If Yes, spec		n, Mexicai Specify:		ican, etc.)		Black, Wh	ite, etc.	
21215-0036	urel', c	d by	3 Widowed			Year o	r Dates:				,					Wh	ite	
15-	n 72 t	Completed		15. Deceder ify only higher		complete			(Giv	edent's Usua e kind of wo DO NOT us	rk done d	during mos	st of working	9		ind of Busines Firm	s/industry	
212	s within	mo du	Elementary/Seco	ndary (0-12)		College	1-4or 5 +		Atto			,			Law	LIIM		
	e filec al Hyg othe vent.	Be C	17. Father's Name (First, Middle	, Last)							18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)		
Maryland	Menta Menta arked atice	5	Waldo W.											cca Dav				
Jar	l 2 sho and r is m		19a. Informant's Na Sian Colo												-	or Town, State,		000
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumatic event. The Medical Examiner runal be inclified at Once.		20a. Method of Disp		/W1I	e		20b. P	lace of Disp	osition (Nar	ne of	1		erville ite		monium, ocation - City o		093
nor	ages ant of it: If it y or o		1 Burial 2	Cremation		emoval fro	m State	-	-	ematory`or o ike Cr				pr 18	Bel	tsville	. Marvl	and
Baltimore,	mit. F partme sorten / injur		21. Signature of Fu			Θ,	ker	3898d	1	2. Name an	d Addres	s of Facili	ity				,	
ä	Depared Important in any ir		15	- Sto	elel	1	~()	1070U						Alteri rive F		ves imore, l	Marylan	đ
			23a. Part1. Enter the shock, or hea	he disease, d rt failure. Lis	r complic t only on	eations the	at caused n each li	the death	n. Do not e	nter the mod	e of dyin	g, such as	cardiac or	respiratory ar	rrest,		Approxim Interval B Onset an	Between
	Fnysician	2 1	Immediate Cause (disease or condition resulting in death)	(Final n	a		60	lon	(a)	ICEM							-	as
	/Medical Examiner		resulting in death)			Due	to (or as	a consequ	uence of):									
	46	e.	Sequentially list confrant, leading to imcause. Enter Under Cause (Disease or	nditions, nmediate	b.	Due	to (or as	a consequ	uence of):									
	outed id ansit	Examiner	cause. Enter Under Cause (Disease of that initiated events	rlying in july	1 .													
o,	sician and burial-transit	Exa	resulting in death) l	Last		Due	to (or as	a consequ	uence of):									
8760,	cate be ex ohysician the buria	dicai			d													
9 X	aath certific attending pl for use as t	/Me	IF FEMALE:		23	Bc. If yes,	outcome	of pregna	ncy		-			*****		23d. Date of d	elivery	
Вох	atten for u	Physician/Me	in the past 12	months?		1⊟Liv	e birth	2 Fetal	death 3	□Ectopic pr □ Other (sp						Month	Day	Year
P.O.	t the c by the	hys	9 Unknown			9□ Ur	known							1				
	n requires that the de been signed by the s should be detached	by	Part II. Other signif	icant condit	ions con	tributing t	o death b	ut not resu	ulting in the	underlying c	ause give	en in Parti	1.		obacco Yes 2	use contribute	to the cause of Probably 4 [
000	law re as bee	plet												24a. Was	SV	24b. Were a	autopsy finding completion o	s available f cause of
E.	The cate h	Completed												perfo 1 🗆 Yes	rmed? 2 X No	death?	s 2 No	
Vita	iicien: The lav certificate has rector, page 2	Be	25. Was case refer examiner?		-	ospital:					Oth			(Check only o				
of	ding Phys	5. To	1 ☐ Yes 2 ₹			1	☐ Inpation Ite of Injuiction the Date of Input		28b. Time	of 2	28c. Injun Wor			le 5 L≱Resid 8d. Describe l		6 □Other (Sp ry occurred	ecity)	
lon	nding nth. :: Afte e fune	ation	1 ZNatural 2 ☐ Accident	5 🗌 Pend inves	ing tigation	(A	fonth, Da	y Year)	Injury	М		k? Yes 2. □]No					
Division of Vital Records,	for Attendiater death. Director: A	Certification:	3 Suicide 4 Homicide	6 🗌 Could deter	not be mined	28e. Pl	ace of In ilding, et	ury - At ho c. (Specif)	ome, farm, s	treet, factor	y, office		2	8f. Location (S City or Tox	Street ai wn, State	nd Number or i	Rural Route No	umber,
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical C	29a. Certifier (Check only one)			er: On th		f examina) and manner a d place, and di		9(s)
	within To thi	Me	29b. Signature and	title of certifi	er	7	7	/)		290	c. Licens	e number			29d. Da	ite signed (Moi	nth, Day, Year)
	200		1/	10			10			1	000	58	79	ے	0		5-05	
1	91		30. Name and addr	ress of perso	Market Co	mpleted c	ause of c	leath (Item	23a) (Type	Jo WI	V5	No.	p KIN	IS No	30	Think	e, 170	2/250
	Sta Regist	ate rar	31. Date filed (Mon	th, Day, Yea	PR	162	2. Registi	ar's Sona	ture	de A	park							

Michael Colglazier TOD: 1:20 AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#1, per#1, 6842.4./18/05 Till State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) William Richard Daniels Sr 2. Date of Death 3. Time of Death Day Month Year Physician 0538 M 2005 /Medical 4c. County of Death 4b Sity, Town, or Location of Death Examiner DALTIMORO AN GAILSTOWN KI LMAR ORD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11 24 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□F Yrs. 32 Director 219-28-1266 MĎ 72 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at XXYes 2 □ No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 U.S.A. or itams 23a 3651 Hilmar Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? ▼TY'es 2 □ No 11 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Heelih and Mental Hygiene. Important: if I tem 27 is marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. Construction Worker 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Brown Berman E. Daniels ္မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 3651 Hilmar Road, Baltimore, Md <u> William R.F. Daniels</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory Inc. 4/11/05 Baltimore, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West Suparture of Funeral Service Licensee, 21215 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications will caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYLEROSCIERONE DECLIOUASCULAR LARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use stribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be þ 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed .24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Pis funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: the Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Funerel [1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifier ٥ APRIL6, 2005 D1117 completed cause of death (Item 23a) (Type, Print) 0 30. Name and appress of person So has LANE ELLIEOTT CITY MARYLADAD

Registrar

DHMH 17 Rev 1/2001

State

SONE 3933 ST.

			For State Registrar	State of Maryland		artment of F			ene g. No. 20	105	13055
	Physici	20	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time of Death
	Physici /Medi		Isaac Dicke	^5				April	12	2005	8:55 PM
	Examir	ner	4a. Facility Name (If not institution, give s	street and number)			r Location of Death		4c. County	of Death	
			5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	NI	O Bidb-li	(04-4
	Funeral Director			M 2 F 75	Yrs.	Months Days	Hours Min.	(Month, Day, Muy 10	Year)	Count	ace (State or Foreign
			Usual Residence of Decedent	7.5				1110g 10,	1797	19	-12.
	rylan how		10a. State 10b. County	10c. City,	Town or Lo	cation				10	d. Inside City Limits
	e Ma	cto	M.D N/a		Bath	mone					1 No 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of		ry?
	ath w	ral	1717 E. Lafey	EHE AVE		21219	5			·S. A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Items 23e or 28e-f show important: If Item 27 Is marked other than "natural" or Items 23e or 28e-f show hy injury or other traumetic event, the Medical Example frame must be rotified at DDE8.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥es 2 □ No If Yes, Give Year or Dates: 		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐/No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
5-0036	2 hou atura cal E	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of B	usiness/Ind	ustry
215	hin 72 nn "nn Medii	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life,	kind of work done of DO NOT use retired	during most of work d)	ing			1
21	filed with Hygiene. ther ther	Com	11	0	Lum	ber worke	r	0	Kumbia	yours	
	be file Ital Hy Id oth	Be (17. Father's Name (First, Middle, Last)		,		18. Mother's Name			ne)	
Maryland	should be and Mental s marked o	ပ	Is was Dick					Sun			
Jar	12 sh and 18 m		19a. Informant's Name/Relationship (Type			1	and Number or Rura		,		
	1 and Health em 27 Ither tr		BERTHU CULD RUTE 20a. Method of Disposition	16		sition (Name of			frman Oc. Location		
Baltimore,	iges if life or of		Burial 2 ☐ Cremation 3 ☐ R	emoval from State cerr	netery, crer	natory or other place	ce)	/	0	,	
Ħ	permit, Pag Department Important: I any injury c		'4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service License		-	CREST CSM			BAIL		
Ba	permit. Departr Importa any inj		21. Signature of Fulleral Service License	41	1/	70 A C	ss of Facility	BEHS &	noze Mi	Her	318
	_		23a. Part1. Enter the disease, or compli	cations that caused the death.	Do not ent	er the mode of dvin	ng. such as cardiac				Approximate
	/Medical Examiner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Find a linear incompage of the cause (Disease or Injury)	Due to (or as a consequen	nce or):	ell Lu	ing ca	nce.C			Interval Between Onset and Death
	and trans	cam	that initiated events resulting in death) Last	Due to (or as a conseque	non of):						
8760,	ate be executed hysician and the burial-transit			Due to (or as a consequen	rice or).						
87	physics the l	dice									
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □Live birth 2 □ Fetal do 4 □ Pregnant at time of deal 9 □ Unknown	éath 3□	Ectopic pregnancy Other (s <i>pecify)</i>	1			te of deliver onth I	y Day Year
	res that igned by be deta		Part II. Dther significant conditions con	tributing to death but not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use conf	ribute to the	cause of death?
ds	luires n sign	d by						1 🗆 Yes	2 🗆 No	3 🗌 Proba	ibly 4 Unknown
of Vital Records,	The law require te has been si age 2 should t	Completed						24a. Was an autopsy perform	ed?	prior to com death?	sy findings available pletion of cause of
ita	ian: irtifica stor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deatl				, ,
>	nysic nis ce I direc	To E	1 Ves 2 No	lospital: 1 x Inpatient 2 ☐ EF	R/Outpatier	t 3 DOA Oth	er: 4 Nursing Ho	me 5 Resider	nce 6 Oth	er (Specify,)
0	ng Pl		27. Manner of Death SNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injun Wor	y at k?	28d. Describe how	v injury occur	red	
Sio	tendi leath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No				
Division	I or Attendi after death. Director: A i in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,		er or Hurai	Route Number,
J	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai Ce	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowled ner: On the basis of examination and manner stated.	edge, deatl n and/or in	n occurred at the tirvestigation, in my o	me, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and mate and place,	anner as sta and due to	ited. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens			d. Date signe	d (Month, E	Pay, Year)
			· Min r	N.D.		AU4176	4581509	1 Apr	4/12	12001	2
	7		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type,	Print)					
5	1		Gideen Blumenth	al MD, 10 A	J. Gr	eene St	Balt?	MOre.	MD	212	01
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re L	Cart o					
	Regist	rar	APR 1 8 2	005 Maries L	7 A	parel					

			1 - For State Registrar	State of Ma		artment of rtificate or		Mental Hygie	4000	13056
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Renneth 4a. Facility Name (If not institution, Maky/and	eonard	Dyson	4b City, Town, Balfin	or Location of Death	/ /	Day Year 13; 2005 4c. County of Death	3. Time of Death
	Funeral Director		5. Social Sebdrity Number 299 - 36 - 0006 Usual Residence of Decedent	Sex 7. Age	(In yrs. last birthday)	If Under 1 Yea Months Days		8. Date of Birth	9. Birth	place (State or Foreign Intry) YORK
	he Maryland 8a-1 show otilied at	ector	10a. State 10b. County Harfor	á	Edgewood	d				10d. Inside City Limits
	eath with the 18 23a or 2	Funeral Director	10e. Street and Number 20 Reeds Rur 11. Marital Status	Rd.	ver in IIS 13.1	210L	10	u.	Citizen of What Cou	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any highly or other traumatic event, if the Medical Examinar must be notified at ance.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1□ Yes 2☑ N			Black, White	, etc. CK
21	filed within 72 Hygiene. other than "nat ant, the Medici	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+	(Give	dent's Usual Occi kind of work don- DO NOT use retir	e during most of wor.	king ,	anitorial	
Maryland	should be filed with and Mental Hygiene. I marked other than umatic event, Ihu	To Be	17. Father's Name (First, Middle, La Joseph Leonard 19a. Informant's Name/Relationship	Dyson	19h Mailir	an Addrose /Strac	Ivetter	ne (First, Middle, Maid Q G. HQA ral Route Number, Ci	RRIS	- Code)
	es 1 and 2 sho of Health and f item 27 Is mu r other traumu		Kumarie Linda 20a. Method of Disposition	Dyson - W	Fe 20 20b. Place of Dispo	Reeds F	Run Rd. E	Edgewood	4	1040
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature 11 meral service Lie	city)	Metro Cr	emotory. Name and Ad	ress of Facility	5-05 Ca		MD Ito MD 21239
	Physician /Medical		23a. Part. Enterthe disease, or co shock, of heart tailure. List or Immediate Cause (Final disease or condition resulting in death)	a. Anoxi	c Ence					Approximate Interval Between Onset and Death
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P.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of deliv	ery Day Year
ecords, P	w requires that been signed t should be deta	by	Part II. Other significant conditions	s contributing to death but	not resulting in the ur	nderlying cause g	iven in Part I.	23e. Did tobacc	co use contribute to t	10
Vital Reco		Completed						24a. Was an autopsy performed 1 Yes 2 X	prior to co	ppsy findings available impletion of cause of
of Vit	Phys this al di	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of leath	Hospital: 1 Inpatient		1 3LI DOA	ther: 4 🗌 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how in		(y)
Division	l or Attending I after death. Director: After I in by the funer	Certification;	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine	(Month, Day)	Year) Injury y - At home, larm, stre		Yes 2 □No	28f. Location (Street City or Town, St	and Number or Run	al Route Number,
Ω	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical Cel	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of e	xamination and/or inv	occurred at the t	ime, date and place, opinion, death occur	and due to the cause red at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number	29d. I	Date signed (Month,	Day, Year)
	1		30. Name and a ress of person with	o p ted cause of dea	ath (Item 23a) (Type, I	Print) Para	iland	General	Lacor	tal
M	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8	2005 32. Projistrar	s Signature	harter				

			State of Maryland /	Department of Health and M Certificate of Death	lental Hygi	-	1205-
>	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last) Danie 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Confes		2. Date of Death Month April	Day Year 13 2005 4c. County of Death N/A	3. Time of Death 11:02 A M
	Funeral Director		5. Social Security Number 216-30-6430 Usual Residence of Decedent 6. Sex 1 X M 2 F 69	rithday) If Under 1 Year It Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, July 25		place (State or Foreign ntry) ryland
	th the Maryland or 28e-f show e notified at	irector	10a. State 10b. County 10c. City, Tow Maryland Baltimore 10e. Street and Number	vn or Location Dunda 10f. Zíp Code		g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ▼No ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Exact and private by inclined at Once.	by Funeral Director	1927 Crafton Ave. 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 1927 Crafton Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	21222 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	United S 14. Race - Ameri Black, White Specify:	can Indian,
121215-0036	iled within 72 ho Hygiene. ther then "netur nt, I'v Medical.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. Years 17. Father's Name (First, Middle, Last)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Electrician	B	6b. Kind of Business/Ir altimore Go Electric (as &
Maryland	should be find Mental Find Find Mental Fin	To Be	Stephen Denisuk	18. Mother's Name Antoi b. Mailing Address (Street and Number or Run	nette D	reiger	n Codel
	iges 1 and 2 solution to the self than the self it is them 27 is or other trau		Mrs. Joan M. Denisuk / Wife 20a. Method of Disposition 1 Denisuk / Wife 20b. Place of Comments Comments	1927 Crafton Ave. Du of Disposition (Name of pry, crematory or other place)	ndalk, M	-	1222
Baltimore,	permit. Pa Departmer Important any injury once.		1 d Donation 5 Other (Specify) Oak La 21. Signature of Funeral Service Licensee	awn Cemetery 4/16/20 22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. Du	Home of	Baltimore, Dundalk, In Maryland 2	Maryland nc. 11222
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68760,	icate be executed physician and s the buriat-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Iritury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence d.				
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Division of Vital Records,	ding Phy I. After this funeral d	ation: To Be	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation			nce 6 Other (Specia	(y)
Divis	ital or Attenderins after deathral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	<i>'</i>	City or Town,		
	To the Hospital or At within 24 hours after or To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledg (Check only one) 2 Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr 29c. License number	ed at the time, dat	use(s) and manner as some and place, and due to due	o the cause(s)
	F 3 F 8	_	30. Name and address of person who completed cause of death (Item 23a)	RES - 000	231	April 13,	
9	,111		DAVID LIM, BMC, 4940 EAST	TERN AVENUE BALTIMO	CE, MD	21224	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8 2005	Joseph			

			1 - For State Registrar			epartment of F Certificate of			Reg. No. 2 0 1	15 3059
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last			4b. City, Town, o	r Location of Dea	2. Date of De Month	Day Y 13 20 4c. County of	
	Funeral Director		5. Social Security Number 6. Se 212-44-8620 Usuel Residence of Decedent	M 20 F	In yrs. last birth	Months Dave	If Under 24 Hi Hours Min		th y, Year)	altimore City Birthplace (State or Foreign Country) Maryland
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examirat must be notified at	ector	10a. State 10b. County Maryland How 10e. Street and Number		Oc. City, Town	Ell	icott City			10d. Inside City Limits
	s 23a or	Funeral Director	4113 Old Columbia Pike			10f. Zip Code	21043			U.S.A.
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show miportant: If item 27 is marked other then "natural", or other traumatic event, the Medical Examinar must be notified at once.	b	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 1 □ Divorced	12. Was Decedent Eve Armed Forces 1 ☐ Yes 2 10 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 250 No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
21215-	filed within 72 h Hygiene. other than "nati ant, the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(0	ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired Busin	during most of w	orking	16b. Kind of Busin	ness/Industry If Employed
Maryland	and Mental Hygid and Mental Hygid is merkad other sumatic evant, it	To Be (17. Father's Name (First, Middle, Last) John Ro 19a. Informant's Name/Relationship (Ty	ov Davis	10h A	Aailing Address (Street a		Ka	Maiden Sumame) thleen Price	70 (0.40)
_	t and 2 s Health ar am 27 is thar trau		Ms. Joann DiMartino 20a. Method of Disposition	Friend		4220 Hermitag			and 21042	
Baltimore,	Pages thent of I tant: If it jury or o		1 Durial 2 Deremation 3 P 4 Donation 5 Other (Specify)	lemoval from State	cemetery,	County Cremato	. l	4/18/2005	20c. Location - Cit	esville, MD
Bal	permit. Pag Department Important: any injury c	2	21. Signature of Funeral Sarvios License	WET BIOL	123	22. Name and Addres	,	ne, P.A.	t City, MD 21	042
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8760,	death certificate be executed be attending physician and indicates as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Cer	ebro	al ede	ema			2 days
O. Box 6	at the death certifica by the attending ph tached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of a 1 Live birth 2 [4 Pregnant at time 9 Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date o Month	f delivery Day Year
rds, P.	w requires that been signed should be det	ρ	Part II. Other significant conditions con	tributing to death but n	ot resulting in th	ne underlying cause give	en in Part I.		_	te to the cause of death? Probably 4 Minknown
of Vital Record	The lay ate has page 2	e Completed	25. Was case referred to medical						med? deat	
	ding Phys n. After this funeral dii	ToB	examiner? 1 Yes 25 Vo H 27. Manner of Death 1 Xelatural 5 Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpa 28b. Tim Inju	e of 28c. Injury ry Work	4 🗌 Nursing I		ence 6 □Other (. ow injury occurred	Specify)
Division	Diri	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	- At home, fam, Specify)	, street, factory, office		28f. Location (Si City or Town	treet and Number on, State)	r Rural Route Number,
	Fur 4	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	er: On the basis of ex	amination and/o	eath occurred at the time r investigation, in my op	inion, death occ	irred at the time, d	ate and place, and	due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	lows	Ze m	29c. License	number) 567	176 1	9d. Date signed (M	Ionth, Day, Year) 13 2005 e(MD21287
*) (30. Name address of person who could be seen address of person address of person who could be seen address of person add	mpleted cause of death	(Item 23a) (Tyl	pe, Print)	oolfe e	5 t - Ba	ltimor	e, MDa 1287
	Sta Registr		APR 1	32. Registra	eur /	19				

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Dea 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 04:27" 2005 L ber. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bon Secours Hospital Baltimore 8. Date of Birth (Month, Day, Year) Sept 17, 1 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days Months 1 X M 2 □ F 1979 25 Yrs Director 067-64-9512 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinat mast be notified at 1 ▼ Yes 2 □ No MD Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1217 W. Fayette Street 21223 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fi iment of Health and Mental H tant: If Item 27 is marked ot Albert Felder Dolly Dickerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42 Hasbrouck Drive Woodbourne, NY 12788 Arthur Felder/brother other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 🖔 Other (Specify) in state permit. Pages Department of a Important: If It any injury or o once. in state State Anatomy Board 655 W. Baltimore Street 21. Signature & Funeral Structor Wade, Director Baltimore, MD 21201 noun Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IMMUNO DEFICIENCY DISORDER Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SSIVE CRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ENCEPHAZOPATHY The taw requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 4□Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No certificate 1 Tyes Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 1**V**OYes 2 No this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After atural 2 Accident 5 Pending 2 No 1 🗌 Yes investigation within 24 hours after death. To the Funeral Director: A filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) ABS HAKAR MD. ZOO (Month, Day, Year) 32. Registrar's Signature State APR 1 8 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink 5 Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MICHAEL JOSEPH FELTY, SR. Month Year 03:15 1. Dru 2005 5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris @ Mercy Medical Ctr. N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Jan 14, 19 Birthplace (State or Foreign Country) 1X M 2□ F 56 Days Hours 214-52-8155 Yrs. 1949 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 Stoll St., 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Tire Mechanic Goodyear MTA 17. Father's Name (First, Middle, Last) 18. Mether's Name (First, Middle, Maiden Sumame) Claude Felty, Jr. Eleanor Meyde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer L. Lewis (Daughter) 911 Stoll St., Baltimore, Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 4/18/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker

22. Name and Address of Facility

MCCully-Polyniak Funeral Home, P.A.

23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 21225-1856 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Cuncer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? prior to completion death? 2 No 2 No 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2- No 2 ER/Outpatient 3 DOA Hospice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Tes 2 No 2 Accident investigation 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Physician /Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, ed by the a Records, P.O. signed the det page 2 s certificate Division of Vital or Attending Physician: director s after death.

I Director: After this of in by the funeral d within 24 hours a To the Funeral I Hospital ha 10

Physician

/Medical

Examiner

Funeral

Director

Show

or Items 23a or 28a-f

"natural"

permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nate any injury or other traumatic evant, tre Marica any injury or other traumatic evant, tre Marica

the Medical Examinant must be notified at

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Certification:

Medicai

29a. Certifier

death with the Maryland

Baltimore, Maryland 21215-0036

2 Medical Examiner: On the basis of rexamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rischero David 31. Date filed (Month, Day, Year)

State Registrar APR 1 8 2005



04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Tem 4a per phys 8842 4-18-05 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year 442 M Ronald /Medical Fritz Apri1 2005 4a. Facility Name (If not institution, give street and number) Ave. 4b. City, Town, or Location of Death 4c. County of Death Examiner 24 Georgin 10 dea If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number If Under 1 Year Days 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 1 M 2 □ F Months Director 204-32-0699 6,1941 Pen<u>nsylvania</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show ary or other treumetic event, It is McColl Examination. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☑ No MarylandAnne Arundel <u>Pas</u>adena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 Belle-of-Georgia Ave. Funeral U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Painter Contracting Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pau1 2 Frederick Fritz Helen Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Fritz (Wife) 4001 Belle-of-Georgia Ave. Pasadena, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite eny injury or ot once. 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Pk. 4/18/05 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause gn each line. Immediate Cause (Final **Physician** disease or condition resulting in death) revioscleratio /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events Due to (or as a consequence of) Examiner the burial-transil and resulting in death) Last Due to (or as a consequence of): the autencing physician Box 68760 th certificate be Physiclan/Medical detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Yes 2 No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 LNo 24a. Was an certificate has autopsy 1 Yes 2 106 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Yes 2 🗆 No 2 this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pendina after death. investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier Deput 29c. License number 29d. Date signed (Month, Day, Year) 0000000 of person who compl. te ause of death (Item 23a) (Type, Print) 30. Name and address 140 695 America ones, mo 6 31. Date filed (Month, Day, Year) State APR 1 8 2005 Registrar

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2005 3062
	Physic /Medi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer 7, 200: 3. Time of Death 7, 200: 524 AM
	Exami	ner	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Country of Death
	Director		212-46-6688 61 Trs. 2/13/1944 Maryland Usuel Residence of Decedent
	he Marylar 18a-f show offilie Jal	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Joppa 1 □ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
nore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23e or 28e-f show ity or other treumetic event. The Medical Examiner must be notified at	To Be Completed by Funeral Director	223 Kearney Drive 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 12. In Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Give kind of work done during most of working life. Do NoT use retired) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. Frentz, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Frentz (Wife) 20a. Method of Disposition 1 Xigurial 2 Cremation 3 Removal from State
Baltimore,	permit. Pag Department Importent: I any injury o		1 Surial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) MD. Veterans Cemetery 2005 Garrison Forest, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221
760,	death certificate be executed Particular and and and are as the buriat-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of): b. Due to (or as a consequence of):
.O. Box 68	at the death certifica by the attending ph tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	The law requires that ate has been signed page 2 should be de	Be Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alguratory clistary with trackers to recommendate to the cause of death? Morbid abbit with thory of part gastine Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death? Les Mas an autopsy findings available prior to completion of cause of death?
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	To the Hospitel or within 24 hours after To the Funerel Direct completely filled in the completely filled in the completely filled in the funerel Direct completely fi	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	To the within 2 To the complet	×	29b. Signature and title of certifier Deneral January Man May May Deneral 17, 2005
15	7117		30. Name and address of person who completed cause of a lath (Item 23a) (Type, Print) BERNARD J. HUKWA, WO, DWE JOIR HOLABIRD AVE BALTO MICE ZIZZZ
ž.	Sta Registr		APR 1 8 2005 32. Régistrar's Signature APR 1 8 2005

			State of Maryland / Departm 1 - Stata Registrar Certific	ent of Health and ate of Death		giene2	005	13063
			Decedent's Name (First, Middle, Last)		2. Date of De	ath		3. Time of Death
	Physici /Medi		Jennie Marie Flynn		Month Apri		2005	10:30 pr
	Examir		4a. Facility Name (If not institution, give street and number) 4b. C	City, Town, or Location of Dea	th		unty of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur	Bel Air nder 1 Year If Under 24 Hrs ths Days Hours Min		th	9. Birthp	lace (State or Foreign
	Director		220-54-8090 54 Yrs.	ths Days Hours Min	6/3/	950		yland
•	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				1	Od. Inside City Limits
	Maryle f sho	5						1 ☐ Yes 2X No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	Maryland Harford Edgewood 10e. Street and Number 10f.	. Zip Code		10g. Citizen	of What Coun	itry?
	h with	ai D	712 Woodbridge Center Way 2	1040		U. S	. A.	
		ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was D	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No		Race - Americ Black, White,	
36	10 - 10	by Fu	1 Never Married 2 Married 1 Yes 2 No	es 2 🔀 No Specify:	,		on ify:	hite
9	72 hours "natural",	ted	15. Decedent's Education 16a. Decedent's 1	Usual Occupation f work done during most of wo	a dein a	16b. Kind	of Business/Inc	
λ⊘ and 21215-0036		Completed	(Specify only highest grade completed) (Give kind on life. DO NC	if work done during most of wo OT use retired)	orking			
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₩ Par	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	Be	17. Father's Name (First, Middle, Last)		, ,		name)	
3	hould d Me mark matic	2	Vincent Alascio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	Ruth Iress (Street and Number or Fi		ley er. City or To	wn. State. Zip	Code)
Z, OB	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In a M. 2010.		CALLY CLASS	E 1,520 525	nter Wa	-	4	21040
/ e	of Health of Health litem 27 i		20a. Method of Disposition 20b. Place of Disposition	(Name of	Date		dgewoo on - City or To	
Sp	Page nent o nt: If iry or		1 □ Burial XX remation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Bayview Cr	ematory 2	/18 005	Balt	imore.	Maryland
a a ti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee 22. Nam-	e and Address of Facility				That y access
B	20 E E S		Richard C. Saffran Sr. 1401	dzinski Fun Old Easter	n Aveni	ome Pa	a ssex,_	MD 21221
`			23a. Part1. Enter the disease, or compositions that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	(~ 6 3
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	unsit	Examiner	cause. Enter Underlying Cause (Disease or injury				-	~5-10 102
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Division of Vital Records, P.	that the polynomial of the pol	by Ph	Part If. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did t	obacco use	contribute to th	ne cause of death?
ds	quires in sign	q pe			10	Yes 2 N	o 3 Prob	ably 4 Unknown
200	aw reis bee	Completed			24a. Was		4b. Were autop	psy findings available
- A	The I	E O			perfo	rmed?	death? 1 ☐ Yes	
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55	Physician: this certific ral director,	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3		Home 5 ☐ Resi			1)
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			Mandre A. Mor MD, Ph. I	FACP DE	2060	04.	-17-	2005
	107		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	on Charalia	lea Desde	re Be	al Air	21014 . MD
	Sta Registr		Dr. Claudia Kroker M.D. 500 Upp 31. Date filed (Month, Day, Year) APR 1 8 2005	er Chesakea	ve DLIA	e 86	4 17 1	, PID

		1.	Registrar Decedent's Name (First, Middle	, Last)								2. Date of Death		<u> </u>	3. Time of Dea
nysici				,	Edw	vard	Foyt					Month Apri	Day 115, 2	Year 2005	12:30 a.
Medic xamin		4a	. Facility Name (If not institution,	, give str	reet and numbe	er)		4b. City,	Town, or	r Location	of Death			ounty of Death	1
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neral		5.		6. Sex	M 2□F	Age (In y	rs. last birthday,	Months	1 Year Days	If Under Hours	24 Hrs. Min.	Date of Birth (Month, Day,	Year)	9. Birth Cos	nplace (State or Fo untry)
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18		-	Da. State 10b. County			10c.	City, Town or L	ocation							10d. Inside City Li
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cal Examiner must be notified at	Completed by Funeral Director	-	De. Street and Number					10f. Zip	Code			10	g. Citize	en of What Co	-
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dical Exactiner must be	nue	11	1. Marital Status		2. Was Decede Armed Force	9 5 ?	n U.S. 13.	Was Deced	dent of H city Cuba	lispanic Ori an, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14	 Race - Amer Black, White 	
ğ	J F		1 Never Married 2 Marri 3 Widowed 4 Divorced		1 ☐ Yes 2 If Yes, Give Year or Date			1 🗆 Yes	2 No	Specify:			S	Specify:	White
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ther1		-20	Ms. Marilyn Wilk Da. Meghod of Disposition	ins	Daug		b. Place of Disp			vvay Eli		ity, Maryland		4∠ ation - City or 1	Town State
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coen signed by the attending physician and should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Ir de constant de	mmediate Cause (Final lisease or condition esulting in death) lequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events asulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. c. d. 23d pons control Hooning gation not be inned Examined	Due to (or Due to (or Due to (or 1 Live birth 4 Pregnant 9 Unknowr ributing to death 28a. Date of I (Month,) 28e. Place of building, cian: To the beer: On the basis	as a cons as a c	sequence of): P	D M DEctopic production of the content and DC of the courred on the course of the courred on th	regnancy pecify)	en in Part I	ambia for cardiac of the cardiac of	23e. Did tob: 1	23d acco use s 2 ed? No) nce 6 [w injury c use(s) ar te and pl d. Date s	id. Date of deir Month e contribute to No 3 Pro 24b. Were aut prior to c death? 1 Yes Other (Special Control of the contro	Approximate Interval Between Onset and Deat Land Deat La
Inter this commands has been also not be detached for use as the burial-transit of timeral director, page 2 should be detached for use as the burial-transit of the burial-transit.	edical Certification: To Be Completed by Physician/Medical	Ind of the control of	mmediate Cause (Final lisease or condition esulting in death) requestiting in death) requestiting is conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events esulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a	Due to (or Due to (or Due to (or C. If yes, outcor 1 Live bith 4 Pregnant 9 Unknowr ributing to death cospital: 1 Inp. 28a. Date of I (Month, 28e. Place of building, cian: To the besident and manner	as a cons as a c	sequence of): Posequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence	D M Ectopic pr Other (sp underlying c	regnancy pecify)	en in Part I	e of Death No nd place, ath occurrent	23e. Did tob: 1	23d acco use s 2 ed? No) nce 6 [w injury c use(s) ar te and pl d. Date s	Id. Date of deir Month e contribute to No 3 prior to codeath? 1 yes Other (Special Control of Prior	Approximate Interval Between Onset and Deat Life William Programme Very Day Year the cause of death obabiy 4 Winking Interval Route Number, stated. to the cause(s)

_			1 = State Registrar	State of Mary		artment of rtificate o		ınd Mer	, ,	ene . No. 2 (105	- 1200
	Physic		1. Decedent's Name (First, Middle, Last) Rose Marie Groos						Date of Death Month	Day 200	Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give st Laurel Regiona	reet and number)	(1	a, or Location o		pril	1, 200. 4c. County Princ	of Death	eorge's
	Funeral Director		5. Social Security Number 6. Sex 212-36-2326	1 053 5	n yrs. last birthday) 6 Yrs.	If Under 1 Ye Months Day		Min. Au	pate of Birth Month Day, Y 1g 20,	1938	9. Birtho	lace (State or Foreign try) Tand
	he Maryland 18e-f show	ector	10a. State 10b. County MD Howard	10	c. City, Town or Lo	rel						0d. Inside City Limits 1 ☐ Yes 2 No
	3e or 3	I Dir	9733 Country Meado	ws Lane		10f. Zip Code	20723		10g	. Citizen of W USA		try?
980	within 72 hours after death with the Maryland ane. then "netural", or Items 23e or 28e-f show the Madical Exaiter frust be truffised at	d by Funeral Director		. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	of Hispanic Orig uban, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race Black		
Baltimore, Maryland 21215-0036	filed within 72 hours Hygiene. ther then "netural", nt, the Medical Exe	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occ kind of work dor DO NOT use ret	cupation ne during most ired)	of working	16	b. Kind of Bus		dustry
yland;	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Henry Howe				18. Mother		st, Middle, Ma Slater	iden Surname		
Mar	nd 2 sho lith and 27 is m		19a. Informant's Name/Relationship (Type Albert J. Groos Sr			og Address <i>(Stre</i> Country						
more,	1 a 1 a 1 a 1 a 1		20a. Method of Disposition 1 Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	2	0b. Place of Dispo			Date		c. Location - 0		
Balti	permit. Pages Department of I Importent: If ite eny injury or of		21. Signature of Funeral Service Licensee Ronald S. Wa	nde Direc	tor St	Name and Add ate Ana Itimore	tomy Bo	pard 65 21201	55 W. B	altimo	re S	treet
	Physician /Medical Examiner		25a. Part 1 Enter the disease or complica shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the cause on each line. Myo Card Due to (or as a co	death. Do not ente	er the mode of d farctio	ying, such as c	eardiac or res	piratory arrest			Approximate Interval Between Onset and Death Howys
,0928	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
P.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	. If yes, outcome of pr 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death 3 [Ectopic pregnar Other (specify)	ncy			23d. Date Mont		y Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions contri Type II Diabetes	buting to death but no Mellitus,	t resulting in the un	nderlying cause o	given in Part I.		23e. Did tobac			cause of death?
al Records,	n: The law re icate has be r. page 2 shi	Completed	Hyperlipidemia,	otid Ar Depressio	11	sease, Inxiet	У	_	24a. Was an autopsy performed	? pri	or to com ath?	sy findings available pletion of cause of
fVit	ysicier ils certif directo	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	pital:	2 ER/Outpatient	3□ DOA C	26. Place o		eck only one) 5 □ Residence	6 ∏Other	(Specify)	
Division of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Inj	ury at ork? Yes 2 No	28d. [Describe how in			
DIV	pitel or Att		4 Homicide determined	28e. Place of Injury - building, etc. (Sp	pecify)	**			City or Town, S	tate)		Route Number,
	he Hos in 24 hc he Funi pletely 1	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examiner	ian: To the best of my : On the basis of examend manner stated.	rknowledge, death mination and/or inv	occurred at the estigation, in my	time, date and opinion, death	place, and d occurred at	ue to the cause the time, date	e(s) and manr and place, an	ner as sta d due to t	ted. the cause(s)
	To 1 To 1	M	29b. Signature and title of certifier			40-	nse number	2 ~	29d.	Date signed (
		-	30. Name and address of person who com	l krug pleted cause of death	(Item 23a) (Type F	2.1.1	228				112	12005
			Soon Kim, M.D.	5808 M	win Stra	ot 1	ElKride	ge, M	D 2:	1075		
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8 2005	Se Hegistrar's S	ignature Aos	de						

CPM 05-02336 William Gilbert

ттсш			1 - State Unpend Item 231,270,28	aryland/	Depa dace nt of the Certificate of the Certificate	beably apad₃M Death		jiene eg. No.		
			Decedent's Name (First, Middle, Last)				2. Date of Dea		15	3. Time of Death
	Physici		William Vincent Gilb	ert			April	O2. 2	Year 2005	22.45 M
	/Medi Examir		4a. Facility Name (If not institution, give street and number		4b. City, Town, or	Location of Death	11P1 11	4c. County		1 44,7)
	Exami		28 East Mt. Vernon Place	Apt. 2M	Malti	more				
()	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last I	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Vacal	9. Birthp	lace (State or Foreign
3	Director		204-38-4598 ^{1໘M 2□F}	56	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day) Sept 2,	1948		nsylvania
()-	D		Usual Residence of Decedent							
	how		10a. State 10b. County MD		wn or Location				1	Od. Inside City Limits
	e-f	cto	FID		Baltimore					1)∑Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of W	/hat Coun	itry?
	ith with the Marylan 23a or 28e-f ehow ust be notified at	al	28 E. Mt. Vernon Place #2	.M	2:	1202		USA		
	iteme	Funeral	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe	cify Yes or No-	14. Race		an Indian,
ထ္	or ite		1 X Never Married 2 Married 1 X Yes 2 If Yes, Give		1 ☐ Yes 2 🕅 No	Specify:		Specify		ite
8	ours irai',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates	:				<i>эрвспу</i>	WII	irce
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23a or 28e-1 ehow ant, the Madical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16	 a. Decedent's Usual Occupa (Give kind of work done of 	during most of working	ng	16b. Kind of Bu	siness/Ind	dustry
2	hen hen	mpl	Elementary/Secondary (0-12) College (1-40)	5+)	life. DO NOT use retired	D)				
2	led v lygie hert		12 0		sales	18. Mother's Name	/Firms & Simbolin I		spap	err
Sur Car	ed at b	Be	Edward Gilbert						9)	
<u>\$</u>	ould Mer Parke	2					ne Prad			
Maryland	2 sh and ts m	0.3	19a. Informant's Name/Relationship (Type, Print) John Magnotti/brother		9b. Mailing Address (Street a			-		
	s 1 and 2 should if Heelth and Mer item 27 is marke other treumatic				2249 South Hi					
Baltimore,	permit. Peges 1 Depertment of He Important: If Iter any injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☒ Other (Specify) in State	e cemei	of Disposition (Name of tery, crematory or other plac		ate	20c. Location -	City of 10	wn, State
Balt	permit. Depertr Importe any inje		21. Signal e Ronald S. Wade, Di	cector	State and Address Baltimore,			Baltimo	ore S	treet
	_		23a. Part1. Boter the disease, or complications that cause shock, ownear failure. List only one cause on each	d the death. Do				est,		Approximate Interval Between
	Physician		Land Control Control		lcohol intoxi	cation				Onset and Death
7	/Medical		resulting in death)	s a consequenc		Callon				
	Examiner									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequenc	e of):					
	d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c.							
ó	icete be executed physicien and s the burial-transit	Ex		s a consequenc	e of):					
68760,	ysicie	edicai	d							
		led						7.		
Вох	Attending Physicien: The law requires that the death certific act death. act death. act After this certificate has been signed by the attending put the function of the form of the function of the form of the function.	Physician/M	IF FEMALE: 23c. If yes, outcom	e of pregnancy 2 DFetal dear	th 3 Ectopic pregnancy			23d. Date	of delive	ry
<u>.</u>	deat e att	Icia	in the past 12 months? 1 Vee 2 No 4 Pregnant a	at time of death	5 Other (specify)			Mon	th	Day Year
P.0	t the by th ache	hys	9 ☐ Unknown			,				
ď.	w requires thet the de been signed by the should be detached	by P	Part II. Dther significant conditions contributing to death	but not resulting	in the underlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to th	e cause of death?
Ö	quire an sig						1 🗆 Ye	s 2 No	3 🔲 Proba	ably 4 \(\square\) Unknown
8	aw re	Completed					24a. Was ar		ere autop	sy findings available
æ	The la ete ha page 2	mo		,			autops	ned? de	eath?	npletion of cause of 2 No
a	ilcien: Th certificete rector, pag	e C	25. Was case referred to medical			26. Place of Death		/	1 1 65	2 140
>	/sicie	To B	examiner? 1X Yes 2 No Hospital: 1 ☐ Inpat	ient 2 ER/C	Outpatient 3 DOA Othe				r (Specify	SCENE
Division of Vital Records,	g Phys er this eral di		27. Manner of Death 28a, Date of Ini	urv 28b	. Time of 28c. Injury		8d. Describe ho			
on	ith. : After s funer	tio	1 Natural 5 Pending 4—2005		M 1 1	res 2X No				
15	Attendii r death. octor: A sy the fu	fice	3 Suicide 6 Could not be 28e. Place of Ir	niury - At home.	and p farm, street, factory, office	2	28f. Location (Street and Number or Rural Route Nu City or Town, State) 28 East Mt.			Route Number,
á	efter Dire	Certification;	- Duliding, e	at home						Maryland
	To the Hospitel or Attending Physicien: Within 24 hours effer deador. After this certific completely filled in by the funeral director,	aic	29a. Certifier 1 Certifying Physician: To the bes	t of my knowled	ge, death occurred at the tim	e, date and place, a	nd due to the ca	use(s) and man	ner as sta	ated.
	D 24	Medical	(Check only one) Medical Examiner: On the basis and manner s	of examination a tated.	ind/or investigation, in my or	pinion, death occurre	d at the time, da	ite and place, a	nd due to	the cause(s)
	To th within To th somp	M	29b. Signature and title of certifier		29c. License		29	d. Date signed	(Month, E	Day, Year)
			Jasher Moont	ser n	OCM OCM	IE.		April 0	3, 20	005
			30. Name and address of person who completed cause of	death()tem 23a) (Type, Print)					
			Tasha 7 Graphora	M.D.	111 Pen	n Street	Baltim	ore, Ma	rylar	nd 21201
	⊮ Sta	te	31. Date filed (Month, Day, Year) APR 1 8 2005	trar's Signature	Acart 1					
	Registr	ar	APR 1 8 ZUUS	1 10 1	A June 1					

		State of Maryland / Depart State of Maryland / Depart State Amend Item 8 per fh G843 5-16-05	rtment of Health and Mer tas liteate of Death	ntal Hygiene 005 13067						
		1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year						
Physi /Med		Allyne Ruth Gonce	Ap	oril 13, 2005 9:15 p M						
Exam	iner	tan and the same to the same t	4b. City, Town, or Location of Death							
		Stella Maris 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Timonium If Under 1 Year If Under 24 Hrs. 8.	Date of Birth 2ar25-1923 thplace (State or Foreign (Month, Day)						
Funera Directo		217-16-1762 1 M 2 T 81 Yrs.		c. 23, 1923 Maryland						
p.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation	10d. Inside City Limits						
anyla shov	7			1 (√ Yes 2 □ No						
the M	ect	Maryland n/a Baltimore	10f. Zip Code	10g. Citizen of What Country?						
th with 23a or	D	$4101\frac{1}{2}$ Old York Road	21218	USA						
death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	/ Yes or No- 14. Race - American Indian, an, etc.) Black, White, etc.						
1215-0036 within 72 hours after death with the Maryland ene. ene. than 'natural', or Itams 23a or 28a-f show the Medical Examinet must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☒ No	☐ Yes 2☐ No Specify:	Specify: White						
215-0036 thin 72 hours aff e. Medical Exam	ed b	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decede	ent's Usual Occupation	16b. Kind of Business/Industry						
oin 72	plet	(Specify only highest grade completed) (Give ki	ind of work done during most of working O NOT use retired)							
d 212 filed withi Hygiene. other than	Completed	1 Legal	Secretary	City of Baltimore						
nd 2 be filed tal Hygir d other avant, 1	Be (17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Sumame)						
Maryland d 2 should be fill the and Mental H 27 Is marked out	10	Elmer J. Beiswanger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Annette Address (Street and Number of Bural Bu	Dohring oute Number, City or Town, State, Zip Code)						
Mary id 2 sho ith and 27 Is my traum		, , , ,	Brewers Drive Perr							
force, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene 1. If itam 271 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Examination in publical.		20a. Method of Disposition 20b. Place of Disposi								
Page:		1 VRurial 2 Cremation 3 Removal from State	Cemetery 4/16/05	Parkville,Maryland						
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra			Name and Address of Facility	1050 York Road						
m 40 = 6	5			Home, Inc. Towson, Md. 21204 Approximate						
		23a. Part1. Enter the dise is a coupling at 4 is that caused the death. Do not enter shock, or heart failur. List on one to use on each line.	r the mode of dying, such as cardiac or re	Approximate Approximate Interval Between Onset and Death						
Physicia: /Medica		Immediate Cause (Final disease or condition resulting in death) a. Almenuscie rothic Conhibtouricular Dijecuse a. Pinal (or assa consequence of):								
Examine		Due to (or as a consequence of):								
73:	Je.	Sequentially list conditions, if any leading to immediate access Settle Underlying.								
and 1-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
8760, Estate be executed hysicien and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):								
876 cate b	dicai	d								
Box 68 death certifical e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery						
BC death	iciar	in the past 12 months? 1 Yes 25No	Ectopic pregnancy Other (specify)	Month Day Year						
P.O. that the ed by the detache	hys	9 Unknown								
cords, P.O. w requires that the deben signed by the should be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ✔nknown						
ords, requires een sign hould be	eted									
10 E S C	Completed			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
te d		OF Manuscriptured to modical	26. Place of Death (C	1 Yes 2 No 1 Yes 2 No						
	o Be	25. Was case referred to medical examiner? 1 Yes 275 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor	5 ☐ Residence 6 ☐ Other (Specify)						
Phy Physical Parts	-	27. Manner of Death 28a. Date of Injury 28b. Time of		. Describe how injury occurred						
Attending Property Attending Property. Sector: After by the funer.	atio	2 Accident investigation	M 1 Yes 2 No							
Division I or Attending after death. Diractor: After	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stre building, etc. (Specify)	et, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)						
Dital of	Ce	29a. Certifier M Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	due to the cause(s) and manner as stated						
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1™ Certifying Physician: To the best of my knowledge, death (Check only one)	estigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)						
Fo the within Fo the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
,		12-	143720	4)14105						
4		30. Name and address of person who completed cause of death (Item 23a) (Type, F MAHMOOD, TARIQ, M.D. 2300 DUL.	Print) ANEY VALLEY ROAD	TIMONIUM MD 21093						
	state	31. Date filed (Month, Day, Year) \$2. Registrar's Signature	2)							
Regi	strar	APR 1 8 2005								

DHMH 17 Rev 1/2001

APRIL 13, 2005

GONCE, ALLYNE

		1 - State Registrer	Department of Health and M Certificate of Death	Reg. N	(10000000000000000000000000000000000000				
Physic /Med Exam	lical	1. Decedent's Name (First, Middle, Last) TUNYA VERNELL 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	APRIL 1	ay Year 3. Time-of Death C. County of Death				
Funera Directo		HARBOR HOSPITAL CENTE 5. Social Security Number 213-96-4243 Usual Residence of Decedent 1 M 2 F 39		8. Date of Birth (Month, Day, Yea 2–18–66	9. Birthplace (State or Foreign Country) Md.				
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-1 show ent, the Medical Exercipar must be notified at	ector	10a. State 10b. County 10c. City, Tow	on or Location altimore	100 (10d. Inside City Limits 1 X Yes 2 □ No				
eath with t	eral Dir	5315 Belleville Ave. 11. Marital Status 12. Was Decedent Ever in U.S.	10f. Zip Code 21207		Citizen of What Country? U.S.A. 14. Race - American Indian,				
0036 rours after dural, or iten	d by Fun	Armed Forces? **Never Married 2 Married 1 Yes & No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White, etc. Specify: Black				
21215-(3 within 72 h 3 jene. or than "natu	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade	Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired) Catering	ng 16b.	Kind of Business/Industry Varies				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items and injury or other traumatic svent, the Medical Examinar mone.	To Be C	17. Father's Name (First, Middle, Last) Lester James N	Mar Mar		Jiles				
and 2 shealth and m 27 is m		Mary Jiles Mother	b. Mailing Address (Street and Number or Rura 5315 Belleville Ave.	, Baltimo	re, Md. 21207				
Baltimore, semil: Pages 1 ar Department of Hea mportant: if item may injury or other one.		1 Rurial 2 Cremation 3 Removal from State Cemete	of Disposition (Name of ery, crematory or other place) Mem. Pk. 4-20-		Location - City or Town, State andallstown, Md.				
Balt permit. Depart Import		21. Signature of Funeral Service License Benned D Jennese	22. Name and Address of Facility March F.H. East		more, Md. 21202 . North Ave.				
Pnysician /Medica Examiner	al er	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury A N 12 x 10	Approximate Interval Between Onset and Death I C DAYS						
68760, cate be executed physician and is the burial-transit	dical Examiner	resulting in death) Last C. Due to (or as a consequence of): d.							
CR IIF ecords, P.O. Box 687 law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgaths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year				
rds, P rds, P quires that n signed b	b	Part II. Other significant conditions contributing to death but not resulting HEPATITIS	in the underlying cause given in Part I.	in Part I. 23e. Did tobacco use contribute to the cause of death 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Onkn					
Reco	Completed	HEPATITIS C							
Vital F Vital F vician: Th	Be	DRUG ABUSE 25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death	*					
JAX TO FILE OK TORE LIFE Division of Vital Records, To the Hospitel or Attending Physician: The law requires to within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be	Certification; To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident 3 Suicide 6 Could not be determined to the determined suicide 1. Page 1. Page 2. Place of Injury - At home, for the could not be determined to the	28d. Describe how inj	and Number or Rural Route Number,					
Division Division To the Hospitel or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Cert	29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination a	City or Town, Sta	s) and manner as stated.					
To the within 2 To the complet	Med	29b. Signature and title of certifier NV Shan Ghay RESIDENT	29c. License number RES 001		ate signed (Month, Day, Year)				
6		30. Name and address of person who completed cause of death (Item 23a) NITA SHANBHAA, PAY III RESIDENT II 31. Date filed (Month, Day, Year) 32. Registrar's Signature	LIAL DIAL CONTRACTOR	TIGSOH HATO	AL -21225 ER STREET, BALTMOREMO				
S	tate	31. Date filed (Month, Day, Year) ADD 1 8 2005 32. Figistrar's Signature	Coerte						

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			For State Registrar				ificate of			Reg. I	2000	13070
,	Physici /Medic	al	Decedent's Name (First, Middle, Last) A	JASSAN			4b, City, Town,	or Location of	U Mo	te of Death	Oay Year 4c. County of Death	3. Time of Death
	Examin	er	SHOCK TRAUMA	A CENT	ER		BALT	MOR	E G	TY	c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 X 2 1 4 - 3 3 - 1 3 6 3 Usual Residence of Decedent	M 2□F	(In yrs. last b	Yrs.	If Under 1 Year Months Days		8. Da Min. (M	te of Brith onth, Day, Yea 09		place (State or Foreign http) MD
	ryland thow		10a. State 10b. County		10c. City, Tov	wn or Loca	ation					10d. Inside City Limits
	the Ma 28a-1 s	Director	MD 10e. Street and Number		Balt	imor	e 10f. Zip Code			100.0	Citizen of What Cou	1xXes 2 □ No
	with 3a or	i Dir	8303 Charmel Dr	ivo				244		10g. (U.S.A.	outy:
	tems 2	nner	11. Marital Status	Was Decedent E Armed Forces?		13. W	as Decedent of l		gin? (Specify Yo	es or No- etc.)	14. Race - Americ Black, White,	
036	rait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland and Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show alory or other traumatic event, the Medical Examiner must be notified at a.	Completed by Funeral	1X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2☐X If Yes, Give Year or Dates:	io	1	Yes 2 No				Specify: Bla	ack
21215-0036	n 72 ho "natu	ietec	15. Decedent's Educ (Specify only highest grade	cation completed)	168	a. Decede (Give ki	nt's Usual Occu ind of work done O NOT use retire	pation during most	of working	16b.	Kind of Business/In	dustry
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Maryland	ld be filed ental Hygi ked other ic event, L	Be	17. Father's Name (First, Middle, Last) Bilal Hassan						r's Name <i>(First,</i> al Ale		en Sumame)	
aryl	2 should be and Mental Is marked of aumatic eve	7	19a. Informant's Name/Relationship (Ty)	оө, Print)	19	b. Mailing	Address (Stree				y or Town, State, Zip	Code)
	1 and 2 Health a lem 27 ls		Bilal Hassan-Fat	her	8:	303_	Charme tion (Name of	1 Dri	ve, Ba			21244
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any injury or othe once		20a. Method of Disposition √Surial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemete	ery, crema	itory or other pla				Location - City or To	
altir	permit. P Departme Importan any njur.		21. Signature of Funeral Service License		King	22.	orial	ess of Facility	у		indallst	Owii, Ma
8	Den imp		frome a	" Mon	1						re, Md	21215
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	cations that caused e cause on each lin	the death. Do	not enter	the mode of dy	ing, such as d	cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a	a consequence	of):	ELIONA	HVA	E			- 31
	Examiner	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	CONVE	Consequence	of):	ASCVI	-AR	MAL	FORT	MATION	LI HRS
	outed Id ansit	Examiner	cause (Disease or injury that initiated events	200 10 (0) 23 (2 0011304001100	3 01).						
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	Jeath certifical attending phy I for use as th	an/M	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 Fetal deat		ctopic pregnanc	су			23d. Date of delive Month	ery Day Year
P.O. Box	that the dea	Physician/Med	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 🗆 (Other (specify) _					
Records, P	sign d be	by	Part II. Other significant conditions con	tributing to death bu	it not resulting	in the und	erlying cause g	ven in Part I.		_	o use contribute to the 2 No 3 □ Prob	he cause of death?
leco	e law requ has been ge 2 shoul	Completed				· · ·			24	a. Was an autopsy performed:	prior to co	psy findings available mpletion of cause of
Vital F		e Co	25. Was case referred to medical					26 Place	of Death (Chec	Yes 2	No 1 Yes	2 No
Ţ	y s	To B	Avainingr?	ospitaf: 1 🗴 Inpatier	nt 2 ER/O	outpatient	3□ DOA Ot	her			6 ☐Other (Specif	iy)
on of	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b.	Time of fnjury	28c. Inju Wo	uryat ork?]Yes 2 □ N		escribe how in	jury occurred	
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۵	urs after aral Direc			building, etc						y or Town, Sta		
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) (Check only one)	ner: On the best of ner: On the basis of and manner sta	examination a	ge, death o ind/or inve	stigation, in my	ime, date and opinion, deat	d place, and duth occurred at the	e to the cause ne time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	Man	~ 1	MD	29c. Licen	0 SS		29d. [Date signed (Month,	Dey, Year)
_	1		30. Name and ddress of person who co	1. 12.	eath (Item 23a)	0	V r	ENE	ST	BALT	IMORE	MD
	Sta Registr	- 12	31. Date filed (Month, Day, Year) APR 1 8	32. Regis)	r's Signature	B.	Conti					
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	1 - State Registrar		-arytania		rtificate			and ivie		giene 2 Reg. No.	005	1307	
ician	1/ W 10	t)			Н	aywo	bod		Date of De Month	Day	Yeer 2005	3. Time of Death	
dical niner	A F 224 At 244 At 15 At 15		mter			Location	of Death			4c. County of Death			
al or	5. Social Security Number 6. Security Number 1		ge (In yrs. Ia 71		If Under Months	1 Year Days	If Under Hours	Min.	Date of Bir (Month, Da 1 2	y, Year)	Cour	place (State or Fore htry) MD	
-	Usual Residence of Decedent 10a, State 10b, County	Town or Lo					10d. Inside						
Director	MD NA 10e. Street and Number		ват	timo	10f. Zip	Code				10g. Citizer	n of What Cou	txXes 2⊡t	
by Funeral	2121 Windsor G 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 2 If Yes, Give Year or Dates:	t Everin U.S ? KNo	. 13. \	1 ☐ Yes	lent of Hi rify Cubar	Specify:	gin? (Speci i, Puerto Ri	fy Yes or No can, etc.)	- 14. Sp		etc. ack	
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			N ₁	urse		18 Mothe	or's Name /	First, Middle.		Baltimore City Ja:			
To Be		ker Sr.						•	М. На		,		
	19a. Informant's Name/Relationship (7				_	(Street a	nd Numbe	er or Rural I	Route Numbe	er, City or T	own, State, Zip	Code)	
	Rosalind Haywo	od-Daugl	20b. Pla	ce of Dispo	sition (Nan	ne of		Stre	et, I		Md	21223 own. State	
	Burial 2 Cremation 3	Removal from State	cer	metery, cren	natory or o	ther place	1						
- OUC	21. Signature of Funeral Service Licensee March Funeral Service Licensee											Mu	
ā	3a. P rt1. Enter the disease, or comphook, or heart failure. List only	J. Tille	TUE	4:	300 1	Vaba	sh A	ve,	Balti		, Md	21215 Approximate	
dical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of triper) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Yea			
by	Part II. Other significant conditions of	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc								co use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
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- To	TE Yes 2 No	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor							me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
ation:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	1 Natural 5 Pending (Month, Day Year) Injury Work?											
Certific	a Constitution to						28	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
edical (29a. Certifier 1 Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examination										
Me	29b. Signature and title of certifier			29c. License number RES-000 nt) Avenue, Baltimore. M					igned <i>(Month,</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month William /Medical Hausmann Jr 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burns 15/21 If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 20 F Director 215-14-4758 81 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. Ite Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 PNo Director Marvland Anne Arundel <u>Pasadena</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1730 Bayside Beach Road death Funerai 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Pres 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. It: If item 27 is marked other than "naturai", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: Š Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 N/A Self Employed <u>Plumber</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Hausmann, Sr. Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene V. Hausmann (Wife) 1730 Bayside Beach Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Pk. 4/19/05 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician /Medical Due to (or as a consequence of): Examiner enmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as | consequence of): Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy should be detached for in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an 1□ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 TSInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Statural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier

6+19

Janamshy-

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

+8006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOF; ROSTEY, 301 HOSVITA KOF

HOSMI

32. Registrar's Signature

	1 - For State Registrer		Maryland / De	epartment of Certificate of			F	Rag. No.	005	131	073
Physician	Decedent's Name (First, Michael Communication)		**				Date of Dea Month	Day	Year	3. Time of	
/Medical	Sonti	R.		yes			APRIL	1	2005	0607	A M
Examiner	4a. Facility Name (If not institut	•		4b. City, Town				4c. Co	ounty of Death	1	
	UNIVERSITY HO		TRAUMA Age (In yrs. last birtho	BALTIMO			8. Date of Birth		NA 0 Birth	plane (Ctata -	- Ci-
Funeral Director	242-21-3974 Usual Residence of Decedent	X M 2□F	30 Yr	Months Day		Min.	8. Date of Birth (Month, Day 4-14-	, Year) -74	Cou	place (State of intry) N.C.	r Foreig
yiano	10a. State 10b. Cour	ty	10c. City, Town o	r Location						10d. Inside Ci	ty Limits
Mar Be-fall	Md.	NA	Ba	ltimore						1X Yes	2 🗌 N
with the Mar s or 28e-f a Lv rutifica Director	10e. Street and Number			10f. Zip Code				10g. Citizer	n of What Cou	intry?	
th wi	706 Appleto	n Street		212	17				USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: If time 72 is marked other than "naturel", or iteme 23a or 28e-f ahow many injury or other treumatic event, it is Medical Everalists must be ricillicated any injury or other treumatic event, it is Medical Everalists must be ricillicated once. To Be Completed by Funeral Director	11. Marital Status 1 ▼Never Married 2 M	If Yes, Give	XNo	13. Was Decedent of If Yes, specify Cu		gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		Race - Ameri Black, White	, etc.	
hour hour	3 Widowed 4 Divorc	1							Вта		
n 72 nale	(Specify only high	ent's Education nest grade completed)	((ecedent's Usual Occ hive kind of work don fe. DO NOT use reti	upation ie during most redl	of workin	g	16b. Kind	of Business/Ir	ndustry	
withi iene. than	Elementary/Secondary (0-12) College (1-4d	or 5+)	borer				Vai	ries		
Hygi Hygi ent, ne C.C.	17. Father's Name (First, Middle	e, Last)			18. Mother	r's Name	(First, Middle,				
hould be fill d Mental H marked ott matic even	Ransom 19a. Informant's Name/Relatio	achin (Tuna Brint)	Hayes	ailing Address (Stre		renda			Battle	in Code l	
d2s th an 7 is 1	Brenda Battle			6 Appleto				•			
1 an Heal Iem 2	20a. Method of Disposition	- Hours	20b. Place of D	sposition (Name of	Ţ.				tion - City or T		
ages nt of t: if it	1X Burial 2 ☐ Crematio		te cemetery,	crematory or other p Mem. Par	,	4-18-			dallst		3
permit. P. Departme Importent any injury once.	* 4 □ Donation 5 □ Other 21. Signature of Funeral Service		KIII	22. Name and Add					e, Md.	21202	
To the Hospitel or Attending Physician. The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and properties and a least the funeral director. To Be Completed by Physician/Medical Examiner	3 Suicide 6 Cou dete 4 Homicide 1 Certifier (Check only one) 2 Medic	Due to (or b. Due to (or d. Du	atient AD ER/Outp. atient AD ER/Outp. an but not resulting in the strength of the strength o	3 Ectopic pregnar 5 Other (specify) ie underlying cause g titient 3 DOA e of 28c. In ry M 1 Street, factory, office eath occurred at the r investigation, in my	26. Place 26. Place ther: 4 \(\) Nur ury at ork? \(\) Yes 2 \(\) \(\)	of Death sing Hom 28	23e. Did to 1 Yes 24a. Was a autops perform 1 Yes (Check only or	bacco use es 2 M sy med? 20 No ence 6 D bacter and N state) Mt M ause(s) an ate and pla	1. Date of delive Month contribute to to the Month of th	bay have Numinal Route Numinal	eath? Inknow availat ause o
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State	30. Name and address of personal address of pe	ice Art	of death (Item 23a) (Ty	pe, Print) 111	Penn S	Stree	et Bal	timor	e, Mary	yland 2	2120

			1 - For State Registrar	State of Ma	ryland		artmen rtificat				ental Hy	giene	71111	5 1	3071
	Physici /Medic Examir	cal	Decedent's Name (First, Middle Lloyd G. 4a. Facility Name (If not institution)	Henson Sr	•					of Death	2. Date of De Month April	12 4c	2005 County of Dea	4:15	of Death
	Funeral Director		8354 Catheri 5. Social Security Number 212-28-7280 Usual Residence of Decedent		(In yrs. last	birthday) Yrs.	Pasa If Under Months				8. Date of Bin (Month, Da Sept.	rth		indel http://dece.com.try) faryla	_
	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show edical Evaninat meat be notified at	Funeral Director	10a. State 10b. County Maryland Anne 10e. Street and Number 8354 Catheri 11. Marital Status	Arundel ne Avenue	Pasa	dena	10f. Zip	211		rigin? (Spe	cify Yes or No Rican, etc.)		izen of What C US 14. Race - Am	1 图 Y country?	e City Limits
2-0036	72 hours after natural', or ite	by	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced 15. Decedent (Specify only highes	If Yes, Give Year or Dates:	1951-	-5 B	If Yes, spect I Yes : dent's Usua kind of wor DO NOT us	2ÅNo	Specify	<i>/</i> :			Black, Wh Specify: BJ ind of Business	lack	
and 2121	be filed withintal Hygiene. It of other than event, the M	Be Completed	Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle, Lloyd Henso)		uck I		er 18. Moth	ner's Name	(First, Middle	, Maiden	tts &	Calla	ahan
е, магу	d 2 shou th and M 7 is mar traumat	To	19a. Informant's Name/Relationsl Lillie Henson 20a. Method of Disposition	nip(Type, Print)	20b. Place	354 of Dispo	Catl	heri	nd Numb	er or Rura Ave.	i Route Numb	er, city o	or Town, State, Md.	21122	
Баштог	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 Cremation 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service	pecify) Licensee	Mary	eter:	Name an	d Addres	s of Facil	Son	s Mort	tuar	wnsvi: y, P.2 Md. 2	A	. bM
	Physician /Medical Examiner		23a. Part1. Enter the disease, in shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused to only one cause on each line a	KE		er the mod	e of dying	g, such as	s cardiac o	r respiratory a	rrest,		Approxin Interval I Onset ar	Between nd Death
,0070	te be executed ysician and ie burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.											
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		Be Completed	25. Was case referred to medical examiner?	/2113(0.					26. Plac	e of Death	24a. Was auto perfo 1 Yes	psy ormed? 2 ⊠No	prior to death?	utopsy finding completion of s 2 No	gs available if cause of
VISION OF V	this a	ertification: To I	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig	ation		Outpatien b. Time of Injury	nt 3 □ DO f 2	8c. Injury Work	4 14	2	ne 5 X Resi 8d. Describe		6 □Other (Spe ry occurred	ocify)	
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	O	3 Suicide 6 Could r determ 29a. Certifier 1 Certifyin 2 Medicel	building, etc.	(Specify) my knowled	dge, death	occurred a	at the tim	e, date a	nd place, a	City or To	wn, State	and manner a	s stated.	
	To the F within 24 To the F complete	Medical	29b. Signature and title of certifier	exeminer: On the basis of e and manner state	9a. 		20-	Linnan				001.5	1 (14)		
3	Sta Registr		30. N and address of person 7	mpleted cause of dea 3 0 A Ky 4 32. Pigistrar	ML	a) (Type,	Print)	BEI	TGI	ATE	RD.	AMM	le signed (Mon	s MO	21401

State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0420 A LONES TPRIL 2005 EDWARD 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northwest Baltimore 3401 Old Ct. Rd. Kardalls town MD pital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1□M 2□ F Yrs. 218-36-5857 65 2-18-40 Director Md Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Exactiner must be notified at 1 √Yes 2 No Directo Md. Pikesville Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Tentmill Lane Apt. J 21208 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 [XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Coltege (1-4or 5+) Head Foreman Life Like Products 12th grade marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Α. Jones Modesta Claiborne James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Tentmill Lane, Rubell Jones Wife Pikesville, Md. 21208 Apt. J 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 4-19-05 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 la March F.H. East 1101 E. North Ave. dig 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner diomyoputhy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit carelle Due to (or as a conse uence of) Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 Tes 2□ No Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 DER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 L Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State 1 8 2005 Registrar

05-246	s L. Ja 6	mes		se Type or Prions 23a,27,28										le.	
AKG	Physic	an	1- For Unpend Ite Registrar 1. Decedent's Name (First, Middle Charles			Cei	<i>tificate</i> James				Date of De	ath		ear ear	3. Time of Death
	/Medi	cal			•						April	8,	2005		5:10 P M
- 0	Examir	ner	4a. Facility Name (If not institution, Johns Hopkins I				Balti		ocation of Dea	ath		4	c. County of	Death	
5446	Funeral	_	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bi	rthday)	If Under 1 \	Year I	f Under 24 Hi		Date of Bir	th You	NA S	. Birthp	lace (State or Foreign
70	Director		217-56-8499	1XM 2□F	53	Yrs.	Months	Days	Hours Mi	n,	(Month, Da 9-14-		"	Cour	Md.
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	or 28	Director	10e, Street and Number				10f. Zip Co	ode				10g. C	itizen of Wh	at Cour	ntry?
	s 23a	ral	1131 Wilmont C			1		212					USA		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Musical Examment must be polified at 2008.	by Funeral	11. Marital Status 1 X Never Married 2 Marrie 3 Widowed 4 □ Divorced	12. Was Decedent Amed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	Vas Deceden f Yes, specify I □ Yes 2X		anic Origin? (Mexican, Pue <i>Specify:</i>	(Specif erto Ric	y Yes or No an, etc.))-	14. Race - Black, Specify:	White,	
5-0	72 ho	eted	15. Decedent' (Specify only highest	s Education	16a	. Deced	lent's Usual C	Occupation	on ing most of w	ndrina		16b.	Kind of Busin	ness/Ind	dustry
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lan	lid be lental rked c	o Be	Charles	L.	Jā	mes	, Sr.			anit			Jackso	n	
ary	shou and M	1-	19a. Informant's Name/Relationsh	ip (Type, Print)	198	. Mailin	g Address (S	itreet and	l Number or F	Rural R	oute Numb	er, City	or Town, Sta	ate, Zip	Code)
	and 2 ealth m 27 I		Julia R. James	Aunt		-	E. 20		Street			re,	Md.	212	18
Baltimore,	Pages 1 ment of H ant: If itel ury or otf		20a. Method of Disposition 1		cemete	ry, cren	sition (Name of natory or other mel Ce	r place)	4-1	Date L8 - C			-ocation - Ci Dundal	•	
Balt	Departiment Departiment Important Incomment In		21. Signature of Funeral Service L	icensee			Name and A						e, Md. North		21202
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	Physician /Medical Examiner	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Figury that initiated events resulting in death) Last	a. Head In Due to (or as b. Due to (or as c.	iuries a consequence a consequence	of):									Interval Between Onset and Death
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rds, P	w requires that the bear signed by should be detact	by	Part II. Other significant condition	ns contributing to death b	ut not resulting i	n the un	derlying caus	se given i	n Part I.			obacco (es 2		ite to th	e cause of death?
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50	r this	. To	1 X Yes 2 No 27. Manner of Death	1 Unpatie	The second second		3□ DOA unk 28c.	Other:	4 Nursing				6 Other (Specify)
8/5	ath. r: After e funer	atior	1 □Natural 5 □ Pending 2 X Accident Investiga	28a. Date of Injui (Month, Day	Year I	njury	М	Work? 1 ☐ Yes	2 X No		bject				
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	To T To I	Σ	29b. Signature and title of certifier	C	00.			cense nu				29d. Da	ite signed (A	fonth, L	Day, Year)
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10 pt	No.		30 Name and address of person w	Tonich -	path (Item 23a)		rint) 111 PEI	NN S	TREET.	BAT	TIMOR	Е.МА	ARYLAN	D 2.1	L201
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	Physici /Medic Examir	al	Decedent's Name (First, Middle, La Herbert W. 4a. Facility Name (If not institution, given the second secon	Johnson		4b. City, Town, or			10 200 4c. County	y of Death	3. Time of Death 12:45 \$
	Funeral Director		214-56-1044		last birthday, Yrs.	Millers If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Bir (Month, Da Aug. 1	Anne Z Year) 3 1950		nder State or Foreign State
Maryland 21215-0036	s should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic svent, it is Medical Examinate must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A 10e. Street and Number 50 Belle Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grave) Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last, Herbert W. 19a. Informant's Name/Relationship (10c. Cit rundel Ann 12. Was Decedent Ever in U. Armed Forces? 1	16a. Dece (Give life. Con:	US 10f. Zip Code 2140 Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 2₺ No dedn't Sual Occupate kind of work done a DO NOT use retired, Structio	spanic Origin? n, Mexican, Pt Specify: ation furing most of 18. Mother's It auline	(Specify Yes or No lerto Rican, etc.) working Name (First, Middle, Jennin Rural Route Numbe	10g. Citizen of 14. Rac Bla Specifi 16b. Kind of B Neal Maiden Surman gs ar, City or Town,	What Cour U ce - Americ ck, White, (y): B1 iusiness/Ini Conc ne)	Od. Inside City Limits 1⊠Yes 2□No ntry? SA can Indian, etc. aCk dustry rete
Baltimore, N	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tra once.		Mary Johnson (S 20a. Method of Disposition **Deurial 2 Cremation 3 C **4 Donation 5 Other (Specification of Service Licer 21. Signature of Funeral Service Licer **H. A.	Removal from State Mail	lace of Disponentery, cre cyland noria Wi	Belle Co position (Name of matary or other place of Nation 1 Park 2. Name and Addres m. Reese	a1 4	Date /16/05 ns Mortu	Laurel ary, P	· City or To	own, State
8760,	Cate be executed Wedical Whysician and Whysician and Examiner The burial-transit	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)	uence of):	21 West ter the mode of dying - MMUNE	g, such as card		rrest,		Approximate Interval Between Onset and Death
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ecords, P.	v requires been sign should be	Completed by Ph	Part II. Other significant conditions o	ontributing to death but not rest	ulting in the u	inderlying cause give	on in Part I.	1 🗆 1	res 2 □ No an 24b.	3 Prob	ably 4 Unknown
DIVISION OF VITAL M	tending Physician: The lav leath. tor: Aller this certificate has the funeral director, page 2	on; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work M 1 ☐ Y	4 X ursin	perio 1 Yes Death (Check only of g Home 5 Resided 28d. Describe h	rmed? 2 No ne) dence 6 Oth	er (Specify red	
N	To the Hospital or Attending Ph within 24 hours after death. To ths Funeral Director: After th completely filled in by the funeral	ledical Certificati	4 Homicide determined 29a. Certifier (Check only one) 2 Medical Example (Check only one)	28e. Place of Injury - At he building, etc. (Specify ysician: To the best of my knoniner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	inion, death o	City or Towace, and due to the accurred at the time,	cause(s) and madate and place,	anner as st and due to	the cause(s)
3		W	29b. Signature and title of certifier 30. Name and address of person who BRIAN C. WAL	CACE, MD	-) 123a) (Type, 9005	Print) 29c. License 3 Print)	1136 2108	RD, BAZ	PRIL TIMORI	d (Month, 1 13, 2 E, Mi	Day, Year) 2005 2(236
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 1 8 2	32. Folistrar's Signa	ture	book		•		/	

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 1, 2005 4:15 PM M Jerome John Kochanski /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 338 Imla Street Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo July 20, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1925 **Funeral** Months Days Hours Min Country) Maryland 1 M 2 □ F 79 220-14-7811 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show eny injury or other traumatic event, it a Medical Examinar must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 √ Yes 2 No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 338 Imla Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: 143-4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 43-46 3 Widowed 4 Divorced Completed unk 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 salesperson 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John James Kochanski Rosa Clara Syblewski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clara Kochanski/sister in law 305 Imla Street Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Sicensee Wade , Director State MANAGEMY Board 655 W. Baltimore Street ran Baltimore, MD 21201 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final estive. Heart 2 month **Physician** disease or condition resulling in death) 6Ma /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physiclan/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ğ in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2. No 1 Yes 2 No 1 Tes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 27. Menner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04/08 12065 D0633 847 >, m0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Baltimore 21224 MO 3509 Easte n Robert MD 31. Date filed (Month, Day, Year)
APR 1 8 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 14, 2005 2:40 P M **Physician** YOUNG OK KIM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. June 30, 1914 Baltimore Manor Care Ruxton Birthplace (State or Foreign Country Republic 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🛛 F 90 Yrs of Korea 537-02-3262 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Manyland 10b County 10a, State Items 23e or 28a-f show f Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28a-f show other treumetic event, Ite Mudical Examinar must be notified at 1 ☐ Yes 2 XNo Completed by Funeral Director Baltimore Owings Mills Maryland 10g. Citizen of What Country? 10e, Street and Number U.S.A. 21117 4723 Ashforth Way 14. Race - American Indian, Black, White, etc. deeth Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or ite ury or other treumetic event, the Medical Examina 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kim ဂ္ဂ Roh Han 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Owings Mills, Maryland 21117 4723 Ashforth Way Duk H. Kim Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Dulaney Crematory protein place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 4-18-2005 Timonium 21. Si nature vinner Serviçe Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23a Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 1 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 **2** No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Certification; i or Attending P after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 4 Homicide within 24 hours a To the Funerel L To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D-0012849 the och in ESLER DY. TOWSON MD 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 MID A:H. GHILADI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		_	For State Registrar	State of	Maryland /		artment of H rtificate of L		and Mental		one 005	13080
	Physici	an	1. Decedent's Name (First, Middle, L Louise	ast) ANN Kr	avbill				_ Mon	of Death	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g				4b. City, Town, or	Location o	Apr.	il 15	4c. County of Dea	1:10 an 1.10 a
	Examin	ier	Brighton Garde		1001)		Towson	Location	, Dodin		Balti	
	Funeral			Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under :	24 Hrs. 8. Date Min. (Mon	of Birth		
	Director		178-01-2670	1□M 2\ F	93	Yrs.	Months Days	Hours	Septe	mber 2	9. Bir 21, 1911 Per	msýlvania
7	2 3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	ocation					10d. Inside City Limits
No.	fsho	ě	MD n/a		Ва	alti	more					1 XYes 2 □ No
Ť.	r 28a	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of What C	ountry?
3	23a o	aiD	3907 Ridgecroft	Road			21 206	5			U.S.A.	
200	leme ler 🗆	Funeral	11. Marital Status	Armed For		13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig	gin? (Specify Yes , Puerto Rican, e	or No-	14. Race - Am Black, Whi	
36	, or i	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or Da	θ΄.		1 ☐ Yes 2 🛣 No	Specify:			Specify:	<i>M</i> hite
d 21215-0036	etural	ted	15. Decedent's	Education		. Dece	dent's Usual Occupa	ation		16	b. Kind of Business	s/Industry
215	, c w	pie	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1	-4or 5+)	life.	kind of work done of DO NOT use retired)	t of working		Б.	
21	ygien ygien t, Ite	Completed	12	n/:		HE	irdresser				Beauty	/
and	ad oth	Be	17. Father's Name (First, Middle, La Julio Ange		alliano				r's Name <i>(First, M</i> rmenia			Denapoli
Maryland	s I am a Should while the meaning to have sales death with the way yet. Health and Monthel Hygiene. I them 27 is marked other than "netural", or iteme 23s or 28s-f show other traumatic event, if a Modical Examinar must be notified at	은	Julio Ange			b. Maili	ng Address (Street a				rgarete City or Town, State,	
2	and call and		Mary McCarthy-A									e, MD21202
ω -	perfill. Fages Failor Depertment of Health a importent: If item 27 is any injury or other training.		20a. Method of Disposition		20b. Place cemete	of Dispo	osition (Name of matory or other place	e)	Date	20	c. Location - City or	r Town, State
imo	nent of I		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ity) Entombi	oldite	ey Va	alley Mem'l	Gard.			Timonium, M	
3alt	Depertriments imported any injuries.		21. Signature of Funeral Service Lic	ensee Willi	am G. Dau	22	2. Name and Addres	s of Facilit	Ruck T	owsor	n Funeral 21204	Home, Inc.
, 111	70'F # 0		23a. Part1. Enter the disease, or co	malinations that or	auged the death. De							Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on ea	ach he.	, not em	41.					Interval Between
	hysician /Medical :		disease or condition resulting in death)	Due to (or as a consequence	of):	of The	13 cm	imis	174-	L .	year
E	xaminer		6 - 1 C. H. F PC	b. =		, .						
	.=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequence	of):						
P	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequence	\ of\:						
Records, P.O. Box 68760,	cate be executed by sician and the burial-transit	a E		Due to (or as a consequence	01).						
687	phys to the	edical	100									
Вох	attending phase as the	W/W	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	h al	∃Ectopic pregnancy				23d. Date of de	,
B	ne atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death		Other (specify)				Month	Day Year
P.O	ned by the a	Physician/Me	9 ☐ Unknown Part II. Other significant conditions			in the	ndorhing on on on	na ia Daet I	230	Did tobar	co use contribute t	o the cause of death?
ds,	signed be de	ğ	array Mar	Desea		III III O U	riderlying cause give	en siraiti.	, 200	1 Tyes	1/	robably 4 Unknown
or	been si	etec	Hung of marin						24a	Wasan	24h Were a	utonsy findings available
Rec	e has	Completed	- Jacobar							autopsy performe	prior to death?	utopsy findings available completion of cause of
	scertificate has t lirector, page 2 s	0	25. Was case referred to medical					26. Place	of Death (Check		No 1 □ Ye	s 2□No
of Vita	nis cer direc	To B	examiner? 1 🗆 Yes 2 🗖 No	Hospital: 1 🔲 li	npatient 2 ER/C	utpatie	nt 3□ DOA Othe	er: 4 □ Nu	rsing Home 5] Residenc	ce 6 ther (Spe	ecity) Livry
0 1	of the state of th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year) 28b.	Time o Injury	Work			cribe how	injury occurred	
Sio	Attending r death. actor: Afte by the fune	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be Ose Diese	of laiver. At home	inem of		Yes 2 🗌		tion (Street	et and Number or B	Tural Route Number,
Division	efter of Direction by	Certification;	4 ☐ Homicide determine	ed 286. Place buildir	of Injury - At home, t ng, etc. (Specify)	arm, st	eet, factory, office		City	or Town, S	State)	arar noble remider,
_	nerei nerei filled	C	29a. Certifier 1 Certifying	Physician: To the	best of my knowledg	je, deat	h occurred at the tim	ne, date an	d place, and due	to the caus	se(s) and manner a	s stated.
2	to the most plan attending righterent. The within 24 hours after death. To the Funeral Bifector: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Ex	aminer: On the ba	isis of examination a per stated.	nd/or in	vestigation, in my op	pinion, dea	th occurred at the	time, date	and place, and du	e to the cause(s)
F	Tot	Σ	29b. Signatur, and title of certific	en	N		29c. License		2	29d	l. Date signed (Mon	th, Day, Year)
•	_		MANA	0//			23	47))	//3	10,5 13	2003
	3	10	30. Name and address of person with the state of the stat	CARONE	e of death (Item 23a)	1	V CHARLE	EJ S	17 51	1 Tim	ore n	2005
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 8 2	2005	egistrar's Signature	An.	de					

		•	1 - For Amend Item 2 State of Marylar Registrar Amend Item 2 per Dr., 684	nd / Department of Health and Certificate of Death	Mental Hygiene Reg. No.	2005 2001
	Dhysici	an	Decedent's Name (First, Middle, Last)		2. Date of Death 04	7- 1 Fact 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
	Physici /Medic	al	DONALD 4a. Facility Name (If not institution, give street and number)	KRAMER 4b. City, Town, or Location of Deat	1	,
	Examin	ęr	Saint Joseph Medical Cer	iter Tows	on	County of Death Halt imore
	Funeral Director		5. Social Security Number 213-20-3661 6. Sex 1 M 2 □ F 7. Age (In yrs. 8. 4. 5. 5. 6. Sex 1 M 2 □ F 8. 6.	. Months Days Hours Min.	8. Date of Birth Month, Day, Year) JUL. 29, 192	9. Birthplace (State or Foreign Country) MD
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Location	4	10d. Inside City Limits
	the Marylar 28a-f show notified at	ctor	MD BALTIMORE	BALTIMORE		1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Cit	izen of What Country?
	s 23e	Funerai	725 MT. WILSON LANE #308 11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	USA 14. Race - American Indian,
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exeminer matter halfied at	by	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puèr 1 □ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, White, etc. Specify: WHITE
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16b. Ki	ind of Business/Industry
2121	within ene.	jumo	Elementary/Secondary (0-12) College (1-4or 5+) 5+	DENTIST	DEN	TISTRY
	be filed tal Hygi d other evant, I	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden	Sumame)
ylaı	should b and Ments marked umatic e	Tof	HARRY	KRAMER SOPHI		MILLSTONE
Maryland	d 2 sh th and th sm 17 is m traum		19a. Informant's Name/Relationship (Type, Print) RUTH KRAMER / WIFE	19b. Mailing Address (Street and Number or R. 725 MT. WILSON LANE #		
	es 1 and 2 should be filed within of Health and Mental Hygiene. I itam 27 is marked other than r othar traumatic evant, the M		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)	T	ocation - City or Town, State
Baltimore,	Page ment cant: If		1 Burial 2 Uremation 3 Hemoval from State	INGTON CHIZUK AMUNO 4/1		BALTIMORE, MD
Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Acensee	22. Name and Address of Facility S(8900 REISTERSTOWN		
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.		c or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) METASTAT	C LUNG CANCER		
	Examiner			qualice oi).		
	it ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):		
•	icate be executed physician and s the burial-transit	Examiner	Cause (Disease of Injury that initiated events c	quence of):		
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			IF FEMALE:			
.O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
Δ,	res that igned b	by Pr	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
ord	w require been sig should b	ted !	DEMENTIA		1 Yes 2	No 3 Probably 4 Unknown
Il Records,	The law rate has be page 2 sh	Completed	CORONARY ARTERY DISEASE		24a. Was an autopsy performed? 1 Yes 28 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No
Vital	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner? Hospital:	0.4	ath (Check only one)	2 TOWN 100-11
ō	g Physical dispersal di	n: To	27. Manner of Death 28a. Date of Day Years	28b. Time of 28c. Injury at	lome 5 Residence 28d. Describe how injur	
ion	Attending r death. actor: Alte	atio	2 Accident investigation	Injury Work? M 1 Tyes 2 No		
Division	at or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Special Countries)	nome, farm, street, factory, office fy)	28f. Location (Street an City or Town, State	d Number or Rural Route Number, s)
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		owledge, death occurred at the time, date and place ation and/or investigation, in my opinion, death occ		
	To the within 2 To tha complet	Ň	29b. Signature and title of certifier	29c. License number D 39254	29d. Dat	te signed (Month, Day, Year)
1	1		30. Name and address of person who completed cause of death (Ite			
1	CA	•		too been 1 1 May 1 to 1	MARYLAND 2	1204
	Sta Registr	_	1 8 2005 Meeus	A Speek		

DHMH 17 Rev 1/2001

ORIGINAL

1- For Amend Item 242 State of Manyland & Departyner to Health and Mental Hygiene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 5:45PM Lincicome Physician April 2005 Daniel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore University Specialty Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug 20, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 1986 **Funeral** Maryland 12M 2□F 18 Yrs. 214-13-3417 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ir than "natural", or Items 23a or 28e-f show the Modical Examiner must be notified at 1 ☑ Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 1105 Landington Avenue by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No hours after 1 Never Married 2 Married white 1 ☐ Yes 2🕅 No Specify: Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than disabled none unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental F 7 Is marked ot Judith Lincicome 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1105 Landington Avenue Baltimore, MD Pages 1 and 2 ment of Health a ent: If Item 27 Is Judy Lincicome/mother 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ě permit. Page Department of Importent: If any injury or State Anatomy Board 655 W. Baltimore Street 21. Signature Ron 1 S. Wade Director Baltimore, MD 21201 mas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chiasi malfermatien Arnoid Pnysician /Medical Due to (or as a consequence of): disorder Examiner Serure Sequentially list conditions, Due to (or as a consequence of f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 2/1No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ANo 1 Yes this certificate Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes 2 XNo Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🔲 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier comenta and D 34 974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARU MEHTA, MD 611, South charles Street, Baltimore, MD 21230 CHARU MEMTA, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) APR 1 8 2005

24a4

32. Registrar's Signature

			• •	Maryland / Dep <i>Ce</i>		ealth and M	lental Hyg	iene 005	13083
	0		Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physici /Medio		Carolyn P. Merriman				April 1	2005 Year	9:20 AM M
	Examir		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or I	Location of Death		4c. County of Death	
			Harford Memorial Hos	pital	Havre	de Grace		Harfo	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	Age (In yrs. last birthday 78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 28,	Year) 9. Birth Cou 1927 Mar	place (State or Foreign ntry) yland
	D .		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation				10d. Inside City Limits
	e Maryla a-f ehov iified at	ctor	MD Cecil		Deposit_				1 ☐ Yes 2√2 No
	3s or 28	Funeral Director	10e. Street and Number 47 Waibel Road		10f. Zip Code	904	1	0g. Citizen of What Cou USA	ntry?
	ms 2	Jera	11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f ehow importants if item 27 is marked other than "natural", or items 23a or 28a-f ehow appring yor other traumatic avent, the Medical Exacting must be redified at once.	by Fur	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give 1 Yes, Give Year or Dat	Ži No	If Yes, specify Cuban 1 ☐ Yes 2 ☒ No	Specify:	Hican, etc.)	Specify: wh:	
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פ	othe othe	a)	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>lar</u>	uid be Aentai rked o	To B	William Dandridge Pi	nkerton		Caro	line Mar	garet Hough	nton
Maryland	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street a	nd Number or Rur	al Route Number	, City or Town, State, Zi	p Code)
	and and m 27 m 27 ner tra		Ellen C. Johnson/daughte		Waibel Roa		Deposit,		
Baltimore,	Pages 1 nent of H ant: If iter ury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☒ Donation 5 ☐ Other (Specify)	ate	oosition (Name of ematory or other place		Date	20c. Location - City or T	own, State
Balt	permit. Departri Imports any inju		21. Signature of Euneral Service Licensee Ronald S. Wade, Dr	1111 -	22. Name and Address tate Anato altimore,	•		Baltimore S	Street
	Physician		23a. Part 1 Enter the disease or complications that can shock) or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	ised the death. Do not er				est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (o	as a consequence of):	TENT	-)4/14/	e		He W days
	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	r as a consequence of):					
,092	eath certificate be executed attending physician and for use as the burial-transit	cai Exa		r as a consequence of):					-
687	ficate p physicate		0.						
.O. Box	0 0	Physician/Med	in the past 12 months?	nt at time of death 5	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delin Month	very Day Year
۵.	s that ned by deta	by Ph	Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause give	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	The law requires that the tite has been signed by the bage 2 should be detached.		Severe Pulmonar	y Fibro	515		1 □ Y	es 2⁴⊡No 3⊡Pro	bably 4 Unknown
900	e law requ has been je 2 shouli	ompleted	Chranic Obstruct	Fre Pul	n drake	Diser	24a. Was a autops	an 24b. Were aut	opsy findings available ompletion of cause of
Ä	The late has page	E	Aratic Charge	1001	no cary	712.00	perfor	med? death? 2₽No 1□Yes	20 No
Vital	certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or	ne)	
of V	Q S	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In	patient 2/2 ER/Outpatie		4 Nulsing H		ence 6 Other (Spec	ify)
u o		on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending (Month	Injury 28b. Time Day Year) Injury	Work		28d. Describe h	ow injury occurred	
Division	ten deat for: the	Certification	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of building	f Injury - At home, farm, s g, etc. (Specify)		fes 2 □ No	28f. Location (S City or Tow	treet and Number or Runn, State)	ral Route Number,
_	Hospitel 24 hours Funerel stely filled	ledical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the barrone 2 Medicel Examiner: On the barrone	is of examination and/or i					
	To the within 2 To the complex	Me	29b. Signature and title of certifier	11	29c. License	number	2	29d. Date signed (Month	, Day, Year)
	> - 0		1 Yhan IN	1164	P	19102	3	April	2, 2005
			30. Name and address of person who completed cause	of death (Item 23a) (Type	e, Print)	7 0.1	071.07	- 1	21001
			Mannel Mlezat	MD	۷	LENV	ande	1 The Va	eer
*.	St	ate rar	31. Date filed (Month, Day, Year) 33 Re	gistrar's Signature	asti I	70-10	John		

DHMH 17 Rev 1/2001

0920 AM

CAROLYN P. MERRIMAN

			. For						i Mental Hyg	_	E 12001	
			1 - State Registrar			Cei	tificate of	Death		Reg. No.: U U	0 13084	_
	Physici		1. Decedent's Name (First, Middle, Last) Catherine Char	lotto M	inoc				2. Date of Dea Month	Day	Year 7:50 P M	
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, o	r Location of De		4c. County of		_
1	LXaiiiii		Sinai Hospital	of Balt	irno	re	Baltin			N/	A	
	Funeral Director		2.2 20 0000	M 2 F 7. Age	7 2	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		y, Year)	9. Birthplace (State or Foreign Country) Mary Land	1
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits	
	Maryl	tor	Maryland N/A		E	Balti	more				1√2 Yes 2 □ No	
	3a or 28a	i Director	10e. Street and Number 3501 Howard Parl	k Avenue	#10)1	10f. Zip Code 2120	7		10g. Citizen of W USA	hat Country?	
36	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ehow any injury or other traumatic event, I're Marieul Examiner must be incliffed at ODGs.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2X N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cubi I ☐ Yes 2 ☐ KNo		(Specify Yes or No- erto Rican, etc.)	Black	- American Indian, k, White, etc. Black	
Baltimore, Maryland 21215-0036	hin 72 hou e. an "natura Modical E	Completed	15. Decedent's Educ (Specify only highest grade		+>	16a. Deced (Give life. I	lent's Usual Occup kind of work done OO NOT use retire	pation during most of v d)	vorking	16b. Kind of Bus	siness/Industry	
7	ed wil	Соп	12th grade 17. Father's Name (First, Middle, Last)			Cas	hier			Super		
yland	wild be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Thomas Simms					Margi				
Mar	od 2 sho Ith and 27 Is m		19a. Informant's Name/Relationship (Ty) Melvin Mines /Hi						Rural Route Numbe	-	State, Zip Code) 21207 Maryland	7
nore,	ages 1 ar not of Hea t: If Item y or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Pla	ace of Dispo metery, cren Idon	sition (Name of natory or other plan Park Cen	metery	19/05	20c. Location - 0	City or Town, State re, Maryland	l
Baltir	permit P Departme Importan any injur		21. Signature 1 uneral Service Ligen	ne us		22	. Name and Addre	ss of Facility	Chatman-		Funeral Hom re,Md 21215	le
	Physician		25a. Part LEnter the disease, or complishock, or heart ailure. List only on Immediate Cause (Final disease or condition	cations that caused	the death.	Do not ent		ng, such as card		rest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):	votic				Venre	
760,	te be executed ysician and e burial-translt	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	na	ence of):	Tailur		<u> </u>		Years	7 4
6876	ficate b physic s the b	edical										
.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of Live birth 4☐ Pregnant at 9☐ Unknown	2 Fetal	death 3□	Ectopic pregnanc Other (specify)	y		23d. Date Mon	e of delivery th Day Year	
a	uires that t signed by d be detac	d by Ph	Part II. Other significant conditions con	tributing to death bu	ut not resul	iting in the u	nderlying cause giv	ven in Part I.			bute to the cause of death? 3 Probably 4 Honknown	
Vital Records,	ne law requir has been si ge 2 should	Completed							24a. Was autop	sy pr med? de	dere autopsy findings available rior to completion of cause of eath?	
ta	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					26. Place of E	1 ☐ Yes Death (Check only on		☐ Yes 2 No	\dashv
<u> </u>	y S	0 B	examiner?	ospital:	nt 2 🔀	R/Outpatien	t 3 DOA Ott	er	Home 5 ☐ Resid		r (Specify)	
Division of	Attending Physician: r death. ector: After this certifica by the funeral director. I	atlon; T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Y Year)	28b. Time of Injury	Wo	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occurre	bd	
Divis	5 th 6	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At hor c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best of ner: On the basis of and manner sta	examinati	rledge, death on and/or in	occurred at the tild vestigation, in my o	me, date and pla opinion, death o	ace, and due to the occurred at the time, o	cause(s) and man date and place, a	nner as stated. nd due to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier				29c. Licens				(Month, Day, Year)	
-	, 1		MAMORO	N				19418			13 2005.	
/	31		30. Name and address of person who co		eath (Item Wes	23a) (Type,	Print) vedere	Ave B	naltimore	MD	21215.	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	re Muse	1 for	uli	paltimore			

DHMH 17 Rev 1/2001

Mines, Catherine.

Thomas Gilbert	MacAuley
05-02511	
RJ	

J		For State Registrar		State	of Mar		partment of ertificate or	Health and M		giene Reg. No.	2005	131	195
		Decedent's Name	(First, Middle	e, Last)					2. Date of De	ath		3. Time of	Death
Physic /Med		Thomas Gi							April	10, 2	2005 Year	08:41	A.M.
Exami	iner	4a. Facility Name (II			u <i>mber)</i>			or Location of Death	1	4c. C	County of Death		
		3614 Phi		11a Koad 6. Sex	7 400	In yrs. last birthda	Abingd		8. Date of Bir		rford Co		- Foreign
Funera Director		219-03-50		1 2 M 2 □ F		yrs. iast birthda 39 Yrs.	Months Day		(Month, Da	y, Year)		place (State of ntry)	r Foreign
		Usual Residence of							02/13	/1916			
unylan show		10a. State	10b. County		1	IOc. City, Town or	Location					10d. Inside Cit	
8a-fa	Directo	MD	Harfo	rd		Abingdon						1 ☐ Yes	ZETNO
21215-UU36 d within 72 hours after death with the Maryland plane. r then "natural", or items 23a or 28a-1 show tre Medical Examiner must be notilized at		10e. Street and Nun	nber				10f. Zip Code				en of What Cou	ntry?	
eath rs 23	eral	3614 Phil	adelph	ia Road 12. Was De	cedent Ev	erin U.S. 1	21009	Hispanic Origin? (Sr	necify Yes or No		S.A. 4. Race - Ameri	can Indian	
fter d	Funeral	1 Never Marri	ed 2 Mari	Armed		5. 11 0.0.	_	f Hispanic Origin? (Sp ban, Mexican, Puerto	o Rican, etc.)		Black, White		
1215-0036 ithin 72 hours af he. nen "natural", or	þ	3 Widowed	4 Divorced	If Yes, C Year or	aive Dates:19	42-1945	1 ☐ Yes 2 🗷 N	o Specify:		5	Specify: Whit	е	
5-0 72 hc	Completed	(Spec	15. Deceden			16a. De	cedent's Usual Occ	upation ne during most of work red)	kina	16b. Kin	d of Business/Ir	dustry	
A diffin	du	Elementary/Secon			(1-4or 5+)			red)	•	Dry (Cleanin	a	
N 000		17. Father's Name (First Middle	i ast)		Dry	Cleaner	18. Mother's Nam	ne (First Middle	Maiden S	Sumame)		
	Be	Bruce Gar						Mary Ali	, ,		amamo,		
Taryla 2 should t and Ment is market	2	19a. Informant's Na				19b. Ma	ailing Address (Stree	et and Number or Ru			Town, State, Zi	Code)	
		Claudia M			r			ad Abingdo					
ite, M s 1 and 2 of Heelth item 27 i		20a. Method of Disp	osition				sposition (Name of rematory or other p	(ace)	Date		ation - City or T	own, State	
altimore, mit. Pages 1 av partment of Hee portant: if item y injury or othe		1 ∐ Burial 2 ['4 ☐ Donation		3 □Removal from pecify)	n State			tory Inc.	Apr 13 2005	Belts	ville,	Marylan	d
Baltimo permit. Page Department of important: if eny injury or		21. Signature of Fu	neral Service	Licensee	1100	051	22. Name and Add	lress of Facility					
n &&.E.5 5		186	- ph	lill-			8717 Green	and Funera Pastures	Drive F	Baltim	es more, Ma	ryland	2128€
		23a. Part1. Enter the shock, or hear	ne disease, or rt failure. List	complications that only one cause or	caused the			ying, such as cardiac	/			Approximate Interval Betwood Onset and D	veen
Physician		Immediate Cause (disease or condition resulting in death)	Final n	_ ai	tect	- guy	LOT Du	und of H	and.	ر		Oliset and L	reatn
/Medical Examiner		resulting in death)		Due to	o (or as a	cons- Juence of):		/					
		Sequentially list con	nditions,	b. — Due to	o (or as a	consequence of):						_	_
nted Insit	Examine	Sequentially list cor if any, leading to im cause. Litter Unde Cause (Disease or	nying =	`	(
J, execu n and ial-tra	Exa	that initiated events resulting in death) L		C. Due to	o (or as a	consequence of):							
8 / 60, cate be executed physician and the burial-transit	cai			d									
. BOX 68/6U, death certificate be executed e attending physician and d for use as the buriat-transit	Po	JF FEMALE:		1									
BOX 68 eath certific attending p	Physician/M	23b. Was decedent in the past 12		23c. If yes, o			3 □Ectopic pregnar	псу		23	3d. Date of deliv Month	,	'ear
at the dea	Sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pre- 9□ Unk		me of death	5 ☐ Other (specify)				WOTH	Day ,	OEI
- F	Phy	Part II. Other signif	icant conditie	ons contributing to	death but	not resulting in the	a underlying cause o	uven in Part I	23e. Did t	obacco us	e contribute to I	he cause of de	eath?
d be d	d by	,					ondonying dadoo s			Yes 2□		10	nknown
w require been si should I	Completed								24a. Was	20	24b. Were auto	ney findings a	vailable
The lav	d H								auto	psy prmed?	prior to co depth?	impletion of ca	use of
VITAI HECOTOS, sician: The law requires t certificate has been signe rector, page 2 should be	C	25. Was case refer	red to medica	1				26. Place of Dea	/\	2 No	1 20 Yes	2∐ No	
	0 B	examiner? 1 XYes 2 □		Hospital:] Inpatient	2 ER/Outpat	ient 3□ DOA	than	ome 5 Resi		☑Other (Speci	y) At s	cene
On Of ding Phy h. After this funeral d	i.i	27. Manner of Death		28a. Dat	e of Injury onth, Day Y	28b. Time	of 28c. Inj	-	28d. Describe			" IIC D	cene
SIOT tendin death. tor: Aff the fur	atlo	1 □ Natural 2 □ Accident	5 Pendir	gation Fo-		: los unkn		☐Yes 2 No	Ele	J81	hot be	1	
DIVISION of Attending after death. I Director: Afte	Certification:	3 Suicide 4 ☐ Homicide	6 🗌 Could determ	inod 289. Pla	ce of Injury ding, etc.	· At home, farm, (Specify)	street, factory, office	ө	28f. Location (City or To		Number or Run	Route Numb	ber,
Dital ours af						repider à			food, A	hugh	- Mayl	wed	-6-
To the Hospital within 24 hours a To the Funeral I Completely filled	edical	29a, Certifier (Check only		Examiner: On the	basis of e	xamination and/or		time, date and place, opinion, death occur					
thin 2 the pthe omple	Med	29b. Signature and	title of certifie		inner state		29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)	
1		1011	P	11 (1 .		OCM	E		Apri	1 10, 2	005	
Or'	V	30. Name and addre	ess of person	who completes ca	use of d	th (Item 23a) (Tvr	e, Print)		4	1			- 1
100		THEODE	1 - 11	King				Penn Stre	eet Bal	timor	ce, Mary	and 2	1201
× S	tate	31. Date filed (Moni		32.	Registrar'	s Signature							
Regis	trar			PR 1 6 20	75	L	# Span	6					
DHMH 17 Rev 1/	2001		H	11 7 0 20	00	STEELE J	20101	de la companya della companya della companya de la companya della					
						ORIGII	VAL.						

			For State	State of M	aryland		artment of F		and Me	,	9	nns	13086
			Registrer 1. Decedent's Name (First, Middle, L	ast)			timodio or	Douth	2.	Date of Dea	Reg. No. ath	000	3. Time of Death
	Physicia			Davis	Lee	Oran	qe		A	Month pril	Day 13,20	Year 005	3:50 P M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location o		<u>*</u>		County of Death	
			108 Shipway				Dunda	alk			E	Baltimon	ce Co.
	Funeral		5. Social Security Number 6.	Sex 7. Ag 1%∑M 2□F	je (In yrs. la	ist birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birt (Month, Day	h v, Ye <i>ar)</i>	9. Birth Cos	place (State or Foreign intry)
	Director		219-22-4877 Usual Residence of Decedent	20 M 201	78	Yrs.			J	uly 10	192	26 Vir	ginia
	and Sw		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary -f sh	to	Maryland Bai	Ltimore				Date	ındalk				1 ☐ Yes 2⊠ No
	r 28e	Director	10e. Street and Number	LCIMOLC	1		10f. Zip Code		MATE		10g. Citiz	en of What Cou	untry?
	th wit		108 Shipway					21	222		Unit	ed Stat	ces
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		5. 13.	Was Decedent of H	lispanic Orig	gin? (Specif	y Yes or No-	- 1	4. Race - Amer Black, White	
36	hours after death with the Maryland tural; or Items 23a or 28e-f show al Examinar must be notified at	by Fu	1 Never Married 2 Married	1 □Yes 2 □ If Yes, Give			1 ☐ Yes 2 ☐XNo	Specify:				Specify:	
8	hour tural	q pe	3 Widowed 4 Divorced 15. Decedent's	Year or Dates:	IWW		dent's Usual Decup	ation			16h Kin	d of Business/l	White
75	in 72 n "net dedica	Completed	(Specify only highest g	rade completed)	F.\	(Give	kind of work done DO NOT use retire	during most	t of working el Wor	1.00	100.101	19 01 0001110001	nacotty
212	d within giene. rr then "	E o	Elementary/Secondary (0-12) 8 Years	College (1-4or	5+)		Plate Mil	_	=I WOI	Ker	S	Steel Tr	dustry
5	al Hygie I other vent, II	ВеС	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name (F	First, Middle,	Maiden S		
<u>Na</u>	2 should be f and Mental H Is marked of aumetic eve	10	Huston Orange							Dummar			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Manylan if Health and Mental Hygiene if them 23s or 28e-1 show item 27 is marked other then "netural", or items 23s or 28e-1 show other traumetic event. Its Modical Examinar must be notified at		19a. Informant's Name/Relationship Brenda Crouse	(Type, Print) (Daughter)			ng Address (Street				-		
d'	of Health of Hem 27 I	1	20a. Method of Disposition	(Daugitter)	20b. Pl		08 Shipwa esition (Name of	ay Du	Indalk Dat	, Mary		ation - City or 1	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 Burial 2 XCremation 3		Ce	metery, crei	matory or other pla						
Ë	artme ortani injury		* 4 ☐ Donation 5 ☐ Other (Special Sign rure of Fineral San in a fineral S			y top	Service (2. Name and Addre	ss of Facilit	4/15/	2005	TOM	son, Ma	ryland
Ba	Depar impo any ir		helle	· fall		D	Name and Address uda-Ruck 1922 Wise	Funer Ave.	ral Ho D u no	ome of dalk,	Dund Mary	dalk, I	1222
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	the death	. Do not ent	er the mode of dyi	ng, such as	cardiac or r	espiratory ar	rest,		Approximate Interval Between
1	Pnysician :		Immediate Cause (Final disease or condition				scular						Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequ	ence of):							
	Examiner	L	Sequentially list conditions,	b. Due to (or as		ertens	im	_					
	ed	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a comequ	ence or):							
	be executed sicien and buriat-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):						-	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai E		d									
9	tificate ng physi as the t	ledi											
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	у			2:	3d. Date of deli	very Day Year
	e dea the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (specify)					Month	Day real
P.0	that the de ed by the a detached t		Part II. Other significant conditions	contributing to death !	out not resu	Iting in the u	nderlying cause an	en in Part I		23e. Did to	obacco us	se contribute to	the cause of death?
ds,	signe d be	d by	-	-		•	, ,	on min and		1 🗆 \			bably 4 Unknown
Sor	w requir been si should	ete	Casari	VE HEAR	. ,	1:000				24a. Was	an	24b. Were au	opsy findings available
of Vital Record	The lav	Completed	Cotonae	y Array		njem				autop perfo	rmed?	prior to death?	ompletion of cause of
ta		0	25. Was case referred to medical					26. Place	of Death (1 ☐ Yes Check only o		1 L. Yes	2 No
<u>></u>	Physicien; this certific ral director,	o B	examiner? 1 □ Yes 2 ※ No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	ER/Outpatier	nt 3 DOA Ott			5 X Resid		Other (Spec	ify)
		n: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui	ay Year)	28b. Time o	f 28c. Inju- Wo	ry at		d. Describe l		occurred	
0	Attendir death. ctor: Af y the fu	atic	2 Accident investigat				M 1	Yes 2□I					
Division	tel or Attendi s after death. el Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	Z80. Place of in	jury - At hor tc. <i>(Specify</i>	me, farm, sti	reet, factory, office		28	Location (S City or Tox		i Number or Ru	ral Route Number,
	pitel ours a ierel [29a. Certifier 12 Certifying	Physician: To the best	of my know	viedne deat	h occurred at the ti	me date an	ud place, and	due to the	Causa(s)	and manner as	stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical		aminer: Dn the basis of and manners	of examinati								
	Fo th Within Fo th	Me	29b. Signature and title of certifier				29c. Licens	se number				signed (Month	, Day, Year)
			M To-	-tmo			Do	0218	359.		4.	14.05	
a	19		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type,	Print)	2/22	2				
d	1 / V	to	31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ure	and MIS	~/~~					
	Registi		BRENTWOOD MED (31. Date filed (Month, Day, Year) APR 18	2005	War s	& A	parte		. <u> </u>				

		Ľ	1 - For Stata Ragistrar	State of	Maryland		artment rtificate			and M		giene	000	15	13087
	Physici		Decedent's Name (First, Middle, Alfred	Last)	λ	Of	for				2. Date of De	Day		Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, University S		A.		fer 4b. City, T Ba		Location o	of Death	APIUL	/2 4c.	County	of Death	7005 M
	Funeral Director		5. Social Security Number 212-60-3270 Usual Residence of Decedent	3. Sex 7 1 X M 2 □ F	. Age (In yrs. Ias	t birthday) Yrs.	If Under 1			24 Hrs. Min.	8. Date of Bir (Month, Da 12-2	th y, Year) 8–53			ace (State or Foreign ry) Md.
	e Maryland 3a-f show Lifted at	Director	Md. 10a. State 10b. County	NA	10c. City, 1		cation :imore				·			10	d. Inside City Limits 1X Yes 2 No
	th with the	al Dire	10e. Street and Number 711 McCabe Ave	э.			10f. Zip C		212			10g. Citi	zen of W US	/hat Counti A	ry?
036	be filed within 72 hours after death with the Maryland Hygione. Hygione. d other than "natural", or Items 23s or 28s-f show event, I're Modical Exeminer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Ford	₹ No		Was Decede If Yes, specif	y Cubar	spanic Ori , Mexican Specify:	gin? (Spo i, Puerto	ecify Yes or No Rican, etc.)			- America k, White, el	tc.
21215-0036	i within 72 ho lene. r than "natur I're Medicel	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give life.	dent's Usual kind of work DO NOT use	done di	urina most	of work	ing		nd of Bu	siness/Indu	ıstry
ਲੂ	ould be filed Mental Hygie tarked other atic event, II	Be	11th grade 17. Father's Name (First, Middle, La Alfred	A.	Of	fer,					(First, Middle,		Sumame	9)	
Maryland	2 should be and Menta Is marked aumatic ev	J.	19a. Informant's Name/Relationshi	p (Type, Print)				Street a		celle or or Run	d Route Numbe	er, City o		rsey State, Zip (Code)
nore, N	ages 1 and nt of Health t: If item 27 r or other tr		Verona Offer 20a. Method of Disposition 1♥ Burial 2 □ Cremation 3	B □Removal from S	tate cem	e of Disponence	sition (Name natory or oth	of er place)		imore,	20c. Lo	cation -	City or Tow	
Baltimore,	permit. Pages 1 and 2 should be Depurtment of Heath and Menta Important: If Item 27 is marked any njury or other traumatic ev once.		21. Signature of Funeral Service Li	* *	ME NE	22	mel Ce Name and March	Address	of Facilit		Ba	alti	nore	, Md. , Md. h Ave	21202
	The law requires that the death certificate be executed with the has been signed by the attending physician and be detached for use as the burial-transit and the property of the control	dical Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A S Due to (o b. UR; i Cue to (s	r as a consequer	nce of): TRA nce ut):						1001,		-	Approximate interval Between Onset and Death
P.O. Box 6	at the death certifi by the attending parached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fetal dent at time of deat	eath 3	Ectopic pred Other (spec					2	23d. Date Mon	of delivery	/ Day Year
rds, P	w requires that been signed b should be deta	Š	Part II. Other significant condition	_ 41	LCER				n in Part I.			obacco u /es 2[bute to the	cause of death?
		Completed	PERSISTENT	VEGE	TATIVE	= 5	STAT	6			24a. Was autop perfo 1 Yes		a de	eatn?	sy findings available pletion of cause of
	ung Phys n. After this funeral di	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending investiga	28a. Date of (Month)		VOutpatien Bb. Time of Injury		Other S. Injury Work	4 □ Nui	rsing Hor	(Check only only one 5 ☐ Resident Resi	dence 6			
Division	i Zi te	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 280. Place o	f Injury - At home g, etc. <i>(Specify)</i>	ə, farm, str	eet, factory,	office			28f. Location (5 City or Tow	Street and m. State)	d Numbe	r or Rural I	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in the Completely	edical	29a. Certifier 1 Cartifying (Check only one) 2 Madical E	Physician: To the base	is of examination	edge, death n and/or in	occurred at restigation, in	the time my opi	e, date and nion, deat	d place, a	and due to the dead at the time,	cause(s) date and	and man place, a	ner as stat	ed. he cause(s)
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2	7			CONTAC	3350	wie	Print) - KGW -				OI BAL				
*	Sta Registi		31. Date filed (Month, Day, Year) APR 1 8 2	005 CE	gistrar's Signatur	Ace	ALL P								

State of Maryland / Department of Health and Mental Hygiene

				J. 10.0 0. 111	y Iwii w / L	_	icate of	Death	•	000	al har	P . other
			1. Decedent's Name (First, Middle, Last	"		Ooran	outo or i	Doutt	2. Dete of De	Reg. No	15	3. Time of Death
	Physicia	an	Carlton		TERS	MA			Month '	Day	Year	1:36 000
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			Keswick Nursing Home					Baltimore			NA	
	Funeral		5. Social Security Number 6. Se	X 7.Ag XM 2□F	e (In yrs. last bir	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	Birthpi Coun	lace (State or Foreign
	Director		227-14-9782		91	Yrs.			March 4	, 1914	Virgi	
	p .		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Locatio					-	0d. Inside City Limits
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	N 9 - 1	Š			Dait	imore						145 165 2 100
	it ti	훔	10e. Street end Number			10	0f. Zip Code			10g. Citizen of W	hat Coun	try?
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	filed within 72 hours after death with the Marylend Hyglene. ther than "natural", or Rems 23a or 28e-f show ent, the Medical Examinat must be notified at	Funeral Director	11. Maritel Status	12. Was Decedent I Armed Forces?	Ever in U,S.	13. Was	Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No	- 14. Race	- Americ	an Indian,
0	or the		1 Never Married 2 Married	1 ☐ Yes 2XX	lo		res 2 🕅 No		o riioari, oto.,			sic.
8	ours	9	3 XWidowed 4 □ Divorced	Year or Dates:			65 ZEE NO	Зреспу.		Specify:	Black	ξ
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a	should be and Mental marked or umatic eve	To B	Phillip Raymond Peters	son				Maggie L.	Potorson			
2	2 shou and M Is mari	-	19a. Informant's Name/Relationship (Ty		19b	Mailing Ac	dress (Street	and Number or Ru		City or Town	State Zin	Codel
N	d2: thar trau		Benjamin Peterson/ Son					enue Baltir			nato, Esp	0000)
o	1 and 3 Health em 27 l	ŀ	20a. Method of Disposition						Date	20c. Location - 0	City or To	um State
Baltimore, Maryland 21215-0020	of T		1 N Burial 2 □ Cremation 3 □ F				n (Name of ry or other plac	(e)	Date	200. LOCATION - C	July of 10	WII, State
ţ	tmer tant:		4 ☐ Donation 5 ☐ Other (Specify)		Woodlawr	1 Cemet	ery	04	¥ − 18 − 05	Baltimore	2, MD	
Sai	parmit. Peg Department Important: i any injury o once.	- 1	21. Signature of Furtural Service Dicens	00/2/2/	/	22. Nar	me and Addres	ss of Facility				
ш	20 F 9 9		37/9000M	WIN		Wylie	Funeral	Home 638 N	J Gilmor	St Rollin	noro	MD 21217
			23a Perce. Enter the disease; or complete speck, or heart failure. List only or	ications that caused	the death. Do r	not enter the	e mode of dyin	g, such as cardiac	or respiratory ar	rest,	DIC,	Approximate
and the same	Physician		Speek, of Healt landre. Elst only of	IO CAUS ON BOOK IN	0.						1	Interval Between Onset and Death
Ĵ	/Medical	.	Immediate Cause (Final		Jeme	NTI	4				1	
8	Examiner		disease or condition resulting in death)	e								
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	icata ba executed physician end s the burial-transit	Examiner). ————————————————————————————————————	1171			Denn	enina	-	1	
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Вох	aath cer attendir I for use	Physician/									1	
o.	ras thet tha da signad by the a ba detached i	30	Part II. Other significant conditions con	tributing to death bu	t not resulting in	the underly	ying cause give	en in Part I.	23b. Dld t	obacco use cont	ribute to	the cause of death?
Ρ.	of the	£							101	fes 2□ No	3 🗆 Prob	ably 4 Unknown
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of Vital Records,	v require been si should l	Completed								an autopsy med?	24b. We	re autopsy findings tilable prior to
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of	Phys this rel d	2	1 ☐ Yes 2 ☐ No '' 27. Manner of Death	1 Inpatier			_ DOA	Aud Nursing Ho		ence 6 Other)
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S	Attending or death. actor: After by the fune	S	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			N		Yes 2□No				
Division	after death after death Director: /	Certification:	4 ☐ Homicide determined	28e. Plece of Inju building, etc		rm, street, fa	actory, office		City or Tow	itreet and Numbei n, Stete)	r or Hural	Route Number,
	ral Dell											
	Hospital 24 hours Funeral ataly filled	edicai	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examir	ician: To the best of	my knowledge, examinetion end	deeth occu	urred et the tim	e, date and place,	and due to the o	ause(s) and man	ner as sta	ated. the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Directomplately filled in by		one)	and manner stel	ed.				at the time, t	unu piauo, ai	.5 506 (0	04436(3)
	To the Vithin 2 To the compla	Σ	29b. Signature and title of certifier				29c. License	number	-	29d. Date signed	(Month, D	lay, Year)
	1.		1 Malling	m no			13	5107	-	Aprill	5	2005
	51	-	30. Name and address of person who co	mpleted cause of de	eth (Item 23a) (Type, Print)	, (5 -	7 1			1
7	9		HILARY DON M	1.D. 10	4 Till	nbri	dat	KUAT :	DALTIM	DEP M	MAY	(An()
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	Registra		APR 1 8 200!	He File	15. A	marke						

		amend item#12,15,18,	- 1	Certificate					1115	1200
Physic		Registrar Decedent's Name (First, Middle, Last) William Roy		Certificate	or Dea	ui	2. Date of De	Reg. No	Year	3. Time of Death
/Med Exami	ner	4a. Facility Name (If not institution, give street a 9514 Dogwood Paus Social Security Number 6. Sex 116 M 20	7. Age (In yrs. Ia	Cay ast birthday) If Under TY	vn, or Location of Tellocation of Te	Hei	8. Date of Bin (Month, Da June 3	Pri		begy's
ō		Usual Residence of Decedent 10a. State 10b. County	10c. City.	, Town or Location					1	l0d. Inside City Lim
a-f sho	ctor	MD Prince Georg	-	Capitol Heig	ghts					1 □ Yes 2 📆
23a or 28 ust be not	Funeral Director	10e. Street and Number 9514 Dogwood Park St	reet	10f. Zip Co		743		10g. Citizen	of What Cour USA	ntry?
a flee within 2 hours are used with the maryland hall tygiens. of other than "natural", or Itema 23a or 28a-f show event, the Mcdraf Examiner must be notified at	b	1 Never Married 2 Married 1 If You	s Decedent Ever in U.S ned Forces? Yes 2 X No 4 es, Give nr or Dates:	13. Was Decedent If Yes, specify			ecify Yes or No Rican, etc.)		Race - Americ Black, White, cify: bla	etc.
"natur	Completed	15. Decedent's Education (Specify only highest grade comp.	leted)	16a. Decedent's Usual O (Give kind of work of life. DO NOT use r	ccupation lone during n	nost of work	ing	16b. Kind of	Business/In	dustry
giene. arthan	Somp	Elementary/Secondary (0-12) unk 11th Coll	lege (1-4 <i>o</i> r 5+)		ıck dr			tran	nsport	ation
ad oth	Be	17. Father's Name (First, Middle, Last)		ur				, Maiden Surr	name)	1
s i and 2 stoud be flied within y f Health and Mental Hygiene. Itam 27 is marked othar than "; other traumatic event, the M. of	To	19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailing Address (S		nise Vo		er, City or Tov	wn, State, Zip	Code) UI
Heal lam		Alberta L. Wall (Fric	20b. Pla	Route 231 P ace of Disposition (Name of metery, crematory or other	of		Prince		ick MI on - City or To	
ant:			state Har	mony Cemete	rv	4/23	/2005	Landov	er, M	
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Physicia /Medic		August Rea	cchia				April	7	2005	725 A N
Examin	_	4a. Facility Name (If not institution, give				r Location of Death	•	_	unty of Death	Λ.
		Mercy Medical 5. Social Security Number 6. Se	Center	yrs. last birthday)	Saltiv If Under 1 Year	nove	8. Date of Birth		h'more	City
uneral irector				35 Yrs.	Months Days	Hours Min.	Oct 11	Year)	Cour	lace (State br Foreightry) ITALY
MOI TE		10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limit
8a-1 st	Director		IMORE		R	OSEDALE				1 ☐ Yes 2 📉N
3a or 2	ai Dire	10e. Street and Number 8218 ANALEE A	VENUE		10f. Zip Code	21237	1	-	of What Cour	ntry?
ems (Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 💆 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give		1□Yes 2█No	Specify:	,,	St		HITE
"natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done	during most of worki	ing	16b. Kind	of Business/In	dustry
riygiene. other than ant, the Ma	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	0)		BET	HLEHAM	STEEL
other /ant,	O	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Su	mame)	
arked o	To B	LEONARDO RE	CCHIA			ORS	OLA		(RECC	HIA)
7 Is matra		19a. Informant's Name/Relationship (T) RUTH RECCHIA/WIFE		1	ng Address <i>(Str</i> eet 18 ANALEE	and Number or Rura		r, City or T D ALE ,		Code) 1237
item 27 other tr		20a. Method of Disposition			osition (Name of matory or other pla		Date		ion - City or To	
ant: If ite ary or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,	nemoval nom State		of Faith		1-2005	BALT	IMORE,	MD
Important: If any injury or once.		21. Signature Funera Sen ce Lione	500	22	2. Name and Addre	ss of Facility CVA	CH/ROSE E ROS	DALE EDALE		HOME 21237
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the one cause on each line.	death. Do not en	ter the mode of dyir	ng, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Meum							24 hrs
aminer			Due to (or as a co	ansequence or,						
#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of):						
ician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):						
attending physician and for use as the burial-trai	calE		d	· · · · · · · · · · · · · · · · · · ·						
ing ph) as th		IF FEMALE:								
attendi for use	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify)	у		230	I. Date of delive Month	ery Day Year
y the	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	e or death St	_ Ottier (specify) _					
signed by the atte d be detached for	by Physician/Med	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the u	underlying cause gr	ven in Part I.	23e. Did to			he cause of death?
been	etec						24a. Was a			ppsy findings availabl
After this certificate has funeral director, page 2	Completed						autop		prior to co death? 1 Yes	mpletion of cause of
ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death				
this ce al dire	ဥ	1 ☐ Yes 2 ☑ No		2 ER/Outpatie	III 3 DOX	ner: 4 ☐ Nursing Ho				ý)
After	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Wo	ryat rk?]Yes 2 □ No	28d. Describe h	ow injury o	ccurred	
Diractor: A I in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tow		lumber or Rura	al Route Number,
To the Funaral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exam	ysicien: To the best of mainer: On the basis of exa	ny knowledge, deat	th occurred at the ti	me, date and place,	and due to the o	ause(s) ar	d manner as s	tated.
ha F	Medi	one) 29b. Signature and title of certifier	and manner stated		29c. Licens				igned (Month,	
= E	_						1	Δ		
Tot		1 1/6/	MD		PLO	807		Apr.	17	2005

Physici	an_	 Decedent's Name (First, Middle, 	Last)	., 200,00	∂99187185 Gertificat			2. Date of Deat	h	
/Media	_	Joseph E. Ric						April 8		6:54 PM M
Examir	ięr	4a. Facility Name (If not institution, Montgomery Gen					ation of Death		4c. County of D	
				Age (In yrs. last bir		1 Year If	Under 24 Hrs.	8 Date of Birth	Montgon	nery Birthplace (State or Foreign
Funeral Director		564-03-2104	1XM 2□F	0.0	Yrs. Months		ours Min.	8. Date of Birth (Month, Day, May 22,	1914 Ne	Country) ebraska
-		Usual Residence of Decedent								
show	_	MD 10a. State 10b. County MD Montgo		10c. City, Tow		_				10d. Inside City Limits
Pag-1	Director		omery	2110	er Sprin					1 ☐ Yes 2X No
nia rygiene. ed other than "natural", or items 23a or 28a-1 show event, the Medical Exertitier mat be rudified at	Ö	10e. Street and Number 17315 Donora Ro	nađ		10f. Zip		105	11	0g. Citizen of What	•
ns 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13 Was Decer	209		activ Ves or No-	USA	mencan Indian.
riter	Fun	1 Never Married 2 Marrie	Armed Force ed 1 2 Yes 2	es?			lexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	
o La	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date	es: '41 - 46	1 ☐ Yes	2⊠ No Si	pecify:		Specify:	white
natu	Completed	15. Decedent's (Specify only highest		16a.	Decedent's Usua (Give kind of wo			ina	16b. Kind of Busine	ss/industry
than "	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. DO NOT us	se retired)	g most of morn	9		
Hygie ther t		17. Father's Name (First, Middle, L			analy		Mashada Na	(Pier A. Adisdalla A.	NSA	
ed of	Be	Eugene Clarence				18.		e (First, Middle, N Alma Ba		
marked o	^L	19a. Informant's Name/Relationshi	to the same of the	196	Mailing Address	(Street and			City or Town, Stat	Zin Codel
27 ls		Joel Richard/son							ng, MD 20	
int of Health and Ment t: If item 27 is marked y or other traumatic e		20a. Method of Disposition		20b. Place o	Disposition (Nan	ne of			20c. Location - City	
ort: If i		1 ☐ Burial 2 ☐ Cremation : 4 ☒ Donation 5 ☐ Other (Sp.		ate cemete	ry, crematory`or o	ther place)	8 1			
Important: If any injury or once.		21. Signatur + of Funeral Service L		rector					. Baltimo	re Street
4 (4)		23a. Parti. Enter the disease or d	complications that cau	sed the death. Do			MD 212 uch as cardiac c		est,	Approximate
ysician		Immediate Cause (Final	only one cause on eac		5		- 4 -			Interval Between Onset and Death
Medical		disease or condition resulting in death)		as a consequence		p00	>17			10 years
aminer		Conventially list annulations	Urina	ary Tract	Infecti	on				1 week
.=	ner	Sequentially list conditions, I any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequanda						
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Myocard		rction	L			1 week
physician and the burial-transit			Due to (or	as a consequence	of):					
phys s the	dical	· · · · · · · · · · · · · · · · · · ·	d							
attending p I for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Date of	delivery
e atte	iciai	in the past 12 months?	4☐Pregnan	n 2 □ Fetal death It at time of death	3 □Ectopic pr 5 □ Other (sp				Month	Day Year
by the tached	hys	9 Unknown	9□ Unknow	n						
signed I	by P	Part II. Other significant condition	ns contributing to deat	h but not resulting i	the underlying ca	ause grven in	Part I.	23e. Did tob	acco use contribute	to the cause of death?
been sig								1 ☐ Ye	s 2 No 3	Probably 4 Unknown
2 5	ompleted							24a. Was ar	24b. Were	autopsy findings available to completion of cause of
page	Com							perform		?
흥 .	Be (25. Was case referred to medical examiner?				26.	Place of Death	Check on one	A	
this cert ral direct	ို	1 ☐ Yes 💥 No	Hospital: 1 Xinp			and the second second	☐ Nursing Hor	me 5 Reside	nce 6 Other (S	pecify)
fter	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of I (Month,			8c. Injury at Work?		28d. Describe ho	w injury occurred	
Director: A	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	nt he	Jahren Alberta G	М	1 🗆 Yes		201 1 1 10		
Direction by	ertification;	4 Homicide determin	ned 286. Place of building,	Injury - At home, fa , etc. <i>(Specify)</i>	rm, street, factory	, office		City or Town		Rural Route Number,
Funeral I	O	29a. Certifier 1 XCertifying	Physicien: To the be	est of my knowledge	death occurred	at the time d	ate and place :	and due to the ca	use(s) and manner	as stated
To the Funeral I	edical	(Check only 2 Medical E	xaminer: On the basi and manner	s of examination an	d/or investigation,	in my opinio	n, death occurre	ed at the time, da	ite and place, and o	lue to the cause(s)
To the complet	ž	29b. Signature and title of certifier				License nur			d. Date signed (Mo	
\$ F 8		PYNO ALL	\rightarrow	•	DO	035045)	Ap	ril 8,200	כו
\$ 2 8		111000								
8 F 8		30. Name and address of cerson w	no completed cause of	of death (Item 23a)	(Type, Print)					

		•	1- For State of Maryland / Registrar		artment of Heartificate of De			gieņe Reg. No.	1115	130	92
	Physici		1. Decedent's Name (First, Middle, Last) Harry Donald Richardso	n			2. Date of De Month	ath Day	Year	3. Time o	f Death M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Lo	ocation of Death	APRII.		County of Death	18:30	_ p
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 579−84−2455 1 M 2 □ F 69	birthday) Yrs.	If Under 1 Year If	Hours Min.	8. Date of Bin (Month, Da Nov. 9	th ly, Year)	rince Ge 9. Birthr Cour 5 Maryl	place (State ontry)	
	ne Maryland 8a-f show offfied at	ector			on Park						ity Limits 2 ∏ No
	th with the	al Dire	10e. Street and Number 21699 Kearsage Place		10f. Zip Code 206	53		10g. Citi;	U.S.A.	ntry?	
980	be filed within 72 hours after death with the Maryland ital Hygiene. In the Maryland other than "natural", or items 23s or 28s-f show event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces v 1 ☐ Yes 2 ☐ Yeo If Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes 2X No S	anic Origin? (Spe Mexican, Puerto I Specify:	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: Wh		
Maryland 21215-0036	within 72 ho lene. 'than "natur ine Medical I	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	on ing most of worki	ng		nd of Business/In	dustry	
land 2	should be filed withlr and Mental Hygiene. marked other than matic event, the Mental Country and the Mental Countr	To Be C	17. Father's Name (First, Middle, Last) Harry Richardson			3. Mother's Name Martha	(First, Middle	Maiden	Sumame)		
	nd 2 sulth ar 27 is r trau		19a. Informant's Name/Relationship (Type, Print) Nancy Tayman (Sister)		ng Address (Street and 199 Kearsag						1 2065
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any injury or othe		'4 Donation 5 Other (Specify)	any	osition (Name of matory or other place) Episcopal		2005	Fore	estville	, Mary	land
Ba	Depa Impo any ii		21. Signature of Funeral Service Licensee		2. Name and Address of 633 Cld Ale						20735
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	æ∫ æ of):		**	or respiratory a	rrest,		Approximal Interval Bel Onset and	tween
68760,	icate be executed physician and the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence d.	e of):							
P.O. Box 6	law requires that the death certific as been signed by the attending pl 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)			2	23d. Date of deliv Month	,	Year
	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting	; in the u	inderlying cause given i	in Part I.			se contribute to t		
al Records,	The ate ha	Completed					24a. Was auto perfo 1 Yes		24b. Were auto prior to co death? 1 \(\sum \text{Yes}	mpletion of d	available ause of
Division of Vital	il or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Many r of Death 1 Valural 5 Pending investigation 3 Suicide 6 Could not be 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, building, etc. (Specify)	Time o	of 28c. Injury at Work? M 1 Yes	t 2 No	me 5 Resi 28d. Describe	dence 6 how injury	d Number or Rura	,	nber,
۵	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	Medical Cer	29a. Certifier (Check only one) X Certifying Physician: To the best of my knowled conditions and manner stated.	lge, deat and/or in	th occurred at the time, ivestigation, in my opini	date and place, a	and due to the	cause(s)	and manner as s	tated. o the cause(s	s)
)	To the within To the comple	Me	29b. Signature and title of certifier Societies and P		29c. License n	umber 2123			e signed (Month,	-4	
	37		30. Name and address of person who completed can of death (Item 23a SHAHID R SIDDIQUI SHAH ASSOC	Н		MD 2063	6				
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 8 2005								

			1 - For State Registrar	State of Marylan	id / Depa	artment of F	lealth and M	Mental Hyg		005	13093
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) MUSCS / Le A 4a. Facility Name (If not institution, give st BALL-MERE VA MED	reet and number)	55 2R	4b. City, Town, o	r Location of Death	2. Date of Dea Month	th Bay	2005 County of Dea	3. Time of Death 615 P M
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5-25-	, Year)	9. Bir	thplace (State or Foreign buntry) Md.
	hours after death with the Maryland turel', or Items 23a or 28a-f ehow a Exacilier coust be rediffed at	Director	Md . 10b. County NA 10e. Street and Number	10c. Cit	y, Town or Lo	timore					10d. Inside City Limits 1 XYes 2 □ No
	23a or	ral Dir	3509 Woodstock Av	æ.		10f. Zîp Code 212	213			en of What Co USA	ountry?
036	ours after death with the Marylan rel', or Items 23a or 28a-f chow Exactinate be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U Armed Forces? Yes 2 ☐ No If Yes, Give Year or Dates: 		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify:	
-6121	hin 72 9. 9n "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)UNY-		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work			d of Business lehem	
ylandz	should be filed within Ind Mental Hygiene. marked other then ' umatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) George	Washingtor		Ross	18. Mother's Name Eliza	e (First, Middle,		Sumame)	kerson
Mar	and 2 should t ealth and Ment n 27 le marked er treumatic e		19a. Informant's Name/Relationship (Typ Karen Williams	e, Print) Friend		*	and Number or Run				Zip Code) 21213
nore,	Pages 1 and of Head Int. If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crei	osition (Name of matory or other place	cθ)			ation - City or	
	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 le marke any injury or other treumatic once.		21. Signature of Funeral Service Licenser Barnad D Oxid		22	n Forest 2.Name and Addre Narch F.H	ss of Facility	9-05 Baltin 1101 E.	ore,	Md.	11s, Md. 21202
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. Living one immediate Cause (Final disease or condition resulting in death)	Period	eRA	. 1	ng, such as cardiac	1		e	Approximate Interval Between Onset and Death 30 VEARS
	Examiner	Examiner	Sequentially list conditions, Tay, wading to miniodiate cause. Enter Underlying Cause (Disease or injury that initiated events	Die to (or as a conseq							
8/60,	cate be executed obysician and the burial-transit	ical	resulting in death) Last	Due to (or as a conseq	uence of):						
ň	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3[Ectopic pregnancy Other (specify)			23	3d. Date of dea	ivery Day Year
rds, P	requires that the een signed by th nould be detache	by	Part II. Other significant conditions cont RENA C + Ai'(4)		ulting in the u	nderlying cause giv	en in Part I.				o the cause of death? robably 4 X Unknown
L Kec	The far ate has page 2	Completed						24a. Was a autops perform	med?	prior to death?	utopsy findings available completion of cause of 2 No
_	ig Physier this neral dil	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation	spital: 1 🙀 Inpatient 2 🗆 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injun Wor			ence 6		cify)
	2 = = -	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Si City or Town		Number or Ri	ural Route Number,
	ek Turk	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) a ate and p	ind manner as place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	(in AA)		29c. Licens				signed (Mont	* '
V-1	1		30. Name and address / son who con	oppleted cause of death (Item	n 23a) (Type,	Print)	(-00	640	HFE	16 12.	2005 - CREMD 21201
10	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8 2005	32. Registrar's Signa	vs M	1010	URVENI	-7/22	「上	4 CTIM	CREMD HAG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#17, perFH, G842, 4/18/05 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** APRIL Year 14, RUBIN ΑM BERTA 2:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 3, 1929 9. Birthplace (State or Foreign Country)
BELARUS 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 76 219-33-3071 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f ehow other traumatic evant. The Medical Examinar rives by notified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 FORDS LANE #524 21215 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 5 1 ☐ Yes 2 1 No Specify WHITE 3 ☐ Widowed 4 ☐ Divorced "natural". 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. ACCOUNTANT MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Mental itam 27 is marked o Yitzok Shvedok YITZOKSHVEDOK CHAIM LEAH MAISES 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 LAURELWOOD COURT - BALTIMORE, MD 21209 FAINA SANDER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 04/15/2005 REISTERSTOWN , MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Finaf Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 mor Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by should be 2 200 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No Yes 1 TYes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2000 Certification: To 1 🗌 Yes Lursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation hours after deat 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide filled in within 24 hours a 29a, Certifiei dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyler stated. npletely ((Check only one) 29d. Date, signed (Month, Day, Year) 29b. Signature nd title of certifier 30. Name and address of person wh of death (Item 234) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

2005

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Baltimore,	nit. Pages entment of ortant: If its injury or o		1	Removal from State)	Ar	butu	s Me	moria	al Park	·			, Maryland
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687	physics the t	dical		d									
Box (leath certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of d	elivery
B.	0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			3 □Ectopic 5 □ Other	pregnancy (specify)				Month	Day Year
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0		\vdash	27. Manner of Death	28a. Date of Injur	гу	28b. Time	e of	28c. Injury	at			jury occurred	лесту) ————————————————————————————————————
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Division	or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc	ury - At h	ome, farm,	street, fact	ory, office			ion (Street or Town, Sta		Rural Route Number,
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George M. Smith 05-2440 AJG

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death April 7, ^D2'005 **Physician** 11:27 A M George M. Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1810 Etting Street unk 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) unk 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 87 217-21-2701 Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Evantinar must be notified at MD Baltimore 1 TYes 2 □ No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 Etting Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: þ 3 ☐ Widowed 4 🕅 Divorced Year or Dates: Completed unk unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 271s marked other than any Injury or other traumatic avent Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17 Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Etting Street Baltimore, MD Clyde Hill/godson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 NOther (Specify) in state 21. Signature of Foneral Savice Licensee Ronal II S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201

23a. Part. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic cardiviascular disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? alcoholism 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 2 No ol or Attending Physician: after death. Diractor: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XXYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene P iuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗷 Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 7, 2005 OCME 30. Name and address of person with completed cause of dat th (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 Greenbera M.D Tasha E 22. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

APR 1 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item/20a-c, 22, per FH, C842, 4-20-05 iT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day April 10, 2005 5:23 PM M Theodore Roemar Schmidt Jr 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 14 Glenwood Road #B Essex Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | May 5, 193 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1⊠M 2□ F 216-36-0558 65 Yrs 1939 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Baltimore 1 ☐ Yes 2 No MD Essex 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 14 Glenwood Road #B 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk College (1-4or 5+) Elementary/Secondary (0-12) restaraunt unk nk18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Theodore Roemar Schmidt Sr Myrtle Catherine Cranston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 403 Academy Avenue Owings Mills, MD 21117 Norma Jean Ernst/friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4/19/05 Metro Catonsville, MD '4 □Donation 5 \\Other (Specify) in state Warch Funeral Rome Signature Funeral Savice Licensee Wade ST Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approximate Interval Between Onset and Death notic Cardio vascular Immediate Cause (Final Arterioscla 10 years disease or condition resulting in death) Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Items 23a

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Pages 1 and 2 should be filed inent of Health and Mental Hygisint: If Item 27 Is marked other

permit. Page Department of Important: If any injury or

Physician

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should be detached

page 2

filled in by the funeral

within 24 hours after death To the Funeral Director: A

The law requires that the death certificate be executed

or Attanding Physician:

To the Hospital

Box 68760,

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of Vital Records,

Division

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To Be

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Baltimore, Maryland 21215-0036

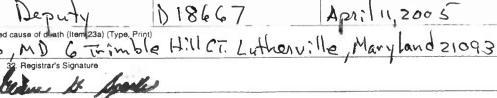
Schmidt

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31. Date filed (Month, Day, Year) APR 1 8 2005

Mame and address of person who con

PHILIP



ated cause of death (Item 23a) (Type, Print)

		•	For State Registrar		State of Ma		epartment of H Pertificate of L			ene 05	13098
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0000	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "natural", or itams 23a or 28a-f show avent, if e Modical Examiner must be notified at	þ	1 Never Man	ried 2 Married 4 ☐ Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give 1 Year or Dates:	941-46	1 ☐ Yes 2 ☐ No	Specify:	nicari, etc.)	Black, Whit	lack
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Ê	Page nent o ant: if ury or		1 XBurial 2 1 □ Donation	☐ Cremation 3 ☐ I 5 ☐ Other (Specify)	Removal from State		ton Cemet		26/05	Arlingto	n, VA.
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	sit s	Examiner	Sequentially list concause. Enter Undo Cause (Disease or	erlying		s consequance of)					
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8/60	tificate be executed g physician and as the burial-transit	edical E			d						
٥	ing phy as th		IF FEMALE:					4.74, 1.74			
o n	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ian/M	23b. Was deceder	nt pregnant	23c. If yes, outcome 1 ☐ Live birth	2 🗌 Fetal death	3 Ectopic pregnancy			23d. Date of de Month	ivery Day Year
j.	the de	hysici	1 ☐ Yes 2 9 ☐ Unknowr		4□Pregnant at 9□ Unknown	time or death	5 Other (specify)				
ν, Γ	requires that the een signed by th hould be detache	by P					ne underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords	require sen si	pleted	пурегсе	ension Co	ongest1v	e Heart	Failure		1 🗌 Ye	s 2 □ No 3 □ P	obably 4 Unknown
r	The lar ate has page 2	Comple	Renal J	Insuffcie	ency				24a. Was ar autops perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
VII	Physician: this certific ral director,	Be	25. Was case refe examiner?		Hospital:		Otho	26. Place of Death		•)	
ō	A 50 D	To To	1 Yes 2 2 27. Manner of Dea	2140	28a. Date of Injur (Month, Day	nt 2 ER/Outpa	atient 3 DOA Care	4 Nursing Ho	me 5 Reside	nce 6 Other (Spe	cify)
0	nding ath. r: Afte	atior	XXNatural 2 Accident	5 Pending investigation		Year) Inju	ry Work	(? /es 2 □ No		,,	
DIVISION	ai or Atte s after des N Diracto	Sertification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc	rry - At home, farm :. (Specify)	, street, factory, office		28f. Location (Str City or Town	eet and Number or Re State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination and/o	leath occurred at the time or investigation, in my op	e, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and	title of certifier		-	29c. License		29	d. Date signed (Mont	h, Day, Year)
			•	410	over	~	D23	181		4-11-200)5
	10		R.G. E	Bhojraj N	MD. 704 (Gorman	$ ext{Ave.,}\# ext{T}-1$	Laure1	, MD. 2	20707	
	Sta Registr		31. Date filed (Mor	nth, Day, Year) APR 1 8 20	32 Angietra	r's Signature					

JEANNE M. SMALL 05-02623 RKD

		•	1- State Unpend Item 2:	State of Maryla 3a&27 per me	nd / Dep G843-5	artment of He -5-05 tas rtificate of De	alth and M eath	lental Hyg	ji ene () 5 leg. No.	13099
	ysicia Nedic		Decedent's Name (First, Middle, Last) Je	eanne Sma	11			2. Date of Dea Month APRIL	Day 14, 20	Year 05 10:15A. M
	amin		4a. Facility Name (If not institution, give s			4b. City, Town, or Lo			4c. County	
			5. Social Security Number 6. Sex		s. last birthday)	ELLICOTT	CTTY Under 24 Hrs.	8. Date of Birth	HOWAR	
Fund Direct				M 2X1F 42			Hours Min.	(Month, Day Nov. 23	3,1962	9. Birthplace (State or Foreign Country) Maryland
be filed within 72 hours after death with the Maryland tal Hygiene.	la La	ior	10a. State 10b. County Maryland Howard		City, Town or Lo					10d. Inside City Limits 1 □ Yes 2 🏋 No
r 28a		Directo	Maryland Howard 10e. Street and Number		llicot	10f. Zip Code		1	l0g. Citizen of W	/hat Country?
th with	S I		8555-D Falls Rur	n Road		21043			U.S.A	(.
er des Itame	Net III	Funeral		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spi Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race	e - American Indian, k, White, etc.
hours after tural', or Ita	Exam	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify	White
in 72 hours af	edical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupation kind of work done durn DO NOT use retired)	on ing most of work	ing	16b. Kind of Bu	siness/Industry
filed within 72 Hygiene.	Nag.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		ting Resear	ch Spec	ialist	Market	Research
be filed tal Hygi	vent,	BeC	17. Father's Name (First, Middle, Last)		11.00		3. Mother's Name			
d 2 should be file th and Mental Hy 7 Is marked oth	natice	2	Robert Earl	Small			Carol	-	ersole_	
- c - N	ır traun		19a. Informant's Name/Relationship (Ty) Timothy Small	Brother		ng Address (Street and Cherokee Dr		al Route Numbel ort Coll		
es 1 an of Heel	r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Dispo	sition (Name of				City or Town, State
Pages Iment of tant: If it	ury o		* 4 ☐ Donation 5 ☐ Other (Specify)		Mem	matorior other place) Valley orial Garde	ens 4-19	-2005	Timoniu	m Maryland
permit. Pages 1 a Department of Hee Important: If Item	any in		21. Signature of Funeral Service License	of Facility Ru Road		on Funer , Maryla	al Home, Inc.			
300			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ations that caused the de	ath. Do not en					Approximate Interval Between
Physic			Immediate Cause (Final disease or condition resulting in death)	Cardiac ar	rhythmi	а				Onset and Death
/Med Exami			resulting in death)	Due to (or as a conse	equence of):					
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be executed	trans	Examiner	cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a conse	aguanaa af):					
icate be executed physician and	2	calE		·	squence or).					
rtificat		edi	IF FEMALE:					111		
the death certificate by the attending physic	for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3[Ectopic pregnancy			23d. Date Mor	e of delivery hth Day Year
the de	ached	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)				
he law requires that the de has been signed by the	ld be det	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause given	in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
s beer	2 shou	ompleted						24a. Was a		Vere autopsy findings available
_ F 5	page	e Com	25 Was seen referred to modical						med? d 2 ☐ No 1	rior to completion of cause of eath? Yes 2 No
(2)	- H	OB	25. Was case referred to medical examiner? 1 XYes 2 No	ospital:	☐ ER/Outpatie	100	6. Place of Death			er (Specify) SCENE
	<u>m</u>	T:uc	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	-	1000	28d. Describe ho		
Attending r death. ector: After	the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 Ye	s 2 No			
- 22 = E	filled in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (Si City or Tow	treet and Numbe n, State)	er or Rural Route Number,
FL 4	completely fill	Medical (29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☒ Medical Examin	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the time, vestigation, in my opin	date and place, ion, death occurr	and due to the c ed at the time, d	ause(s) and mai late and place, a	nner as stated. and due to the cause(s)
To the within 2 To the	comp	Me	29b. Signature and title of certifier			29c. License n	umber	2	29d. Date signed	(Month, Day, Year)
		114	when	MI		OCME		A	APRIL 15	,2005
(13)			30 and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print) 111 Pe	enn Stre	et Balı	timore,	Maryland 21201
3	Sta	te	31. Date filed (Month, Day, Year)	82. Registrar's Sig	nature	· ·				-
Re	gistr	ar	APR 1 8 2005	Marie 1	Cons	20				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Susan С. Suchnick April 14. 2005 10:35pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Joseph Richey Hospice Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2∏F 90 1914 199-07-2330 Mcihigan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show treumetic event, the Medical Examinar must be notified at 1 X Yes 2 No Baltimore Maryland n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 435 Gillespie Street 21225 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 140 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ŏ 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) 5 years Homemaker Own Home n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stella Moskwa Walter Cialek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 Gillespie Street, Baltimore, Md. 21225 19a. Informant's Name/Relationship (Type, Print) Melvin J. Suchnick (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Holy Cross Cemetery 4-18-2005 Brooklyn Park, MD * 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home, P. A. 21225 21. Signature of Funeral Service Licensee J. Wayne Osterling 23a. Pa M. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final diseas) or Control on Esophage (ance 100.15 **Physician** diseas are conding resulting in death) /Medical Due to (or as a construence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 XNo 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2. No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗀 Suicide 4 Homicide 29a. Certifier Medical

Box 68760. Division of Vital Records, P.O.

Maryland 21215-0036

Baltimore,

Hospital or Attending Physicien: To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) JHBMC Rm 235

MD 4940 Eastern Ave. Kalhmare 21224

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

BMC B2N
2005
32. Red Strar's Signature

			For	State of Maryland				nd Men	tal Hyg	iene		
			State Registrer		Cer	tificate of l	Jeath		Pate of Deat	eg. Nd.	5 1.3 1.0	
	Physicia	រា	1. Decedent's Name (First, Middle, La Grace M	Smith				- 1	Month Pri		Year 3:45	5 A M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of I	for	1	4c. County o	of Death Arundel	
	Funeral			Sex 7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24	Hrs. A	Date of Birth Month, Day,	Year)	Birthplace (State or in Country)	Foreign
	Director	-	212-20-8210 Usual Residence of Decedent	1□M 2🕪 80	Yrs.	Monato Boyo			an. 15	5, 1925	Maryland	
	aryland show		10a. State 10b. County	10c. City, T		cation					10d. Inside City	
	the Ma 28a-f	Funeral Director	Maryland Anne A	rundel Pasac	dena_	10f. Zip Code			1	0g. Citizen of W	hat Country?	
	3a or		2048 Poplar Ridge	e Road		21122				U	J.S.A.	
	death	Jera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	ispanic Origi	n? (Specify Puerto Rica	Yes or No-		- American Indian, k, White, etc.	
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. ad thylygiene. ad other than "natural", or itams 23a or 28a-f show event, I're Madical Examinal must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2⊡No			,	Specify:		
2-00	72 hou natural	Completed by	15. Decedent's (Specify only highest g	Education	(Give	dent's Usual Occup	during most d	of working		16b. Kind of Bu	siness/Industry	-
121	e filed within al Hygiene. I other than " vant, Ire Mas	ompi	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		DO NOT use retired COUNTANT	J)			Produc	ce Market	
Maryland 21215-0036	be filed ntal Hygi ed other evant, Il	Be	17. Father's Name (First, Middle, Las					's Name <i>(Fi</i> SWORth		Maiden Sumam Brown	Θ)	
aryla	s 1 and 2 should be f Health and Mental item 27 Is marked o other traumatic eve	2	Graham 19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street						
	ss 1 and 2 of Health a item 27 ls other tra		Charles M. Smith	20b. Plac	e of Dispo	sition /Name of		ad Gr Date			yland 21639 City or Town, State	
more	Pages 1 ment of H ant: If ite ury or ot		1 ■Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec	☐Removal from State cem	netery, cre	natory or other place Park Cem		/16/0	5	Baltimor	re, Marylan	d
Baltimore,	permit. Pages Department of Important: If it any injury or o once.		21. Signature of Funeral Service Lic	A CONTRACTOR OF THE PARTY OF TH	1	2. Name and Addre IcCully-P 3204 Moun	olynia	k Fun Coad P	eral l asade	Home P.	A. ÿlánd 21122	
			23a. Party. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. ly one cause on each line.							Approximate Interval Betw Onset and D	een
	Physician /Medical	n I	Immediate Cause (Final disease or condition resulting in death)	a. CARDIOVASC		R ACC	IDEN	T				
	Examiner		Conversion lies conditions	Due to (or as a consequent	FIB	RILLAT	102					
	ed sit	niner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	HYPERTE	•	100						
ó	sate be executed by sician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):							
8760,	icate be physici s the bu	dical		d. DEMONTI	A							
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Dat Mo	te of delivery nth Day Y	ear
<u>α</u>	uires that signed by	b	Part II. Other significant condition	s contributing to death but not result	ing in the u	underlying cause gr	ven in Part I.				ribute to the cause of de 3 ☐ Probably 4 ☑0	
Records,	The law requir ate has been si page 2 should	Completed						_		rmed?	Were autopsy findings a prior to completion of cadeath? 1 □ Yes 2 ☑ No	available ause of
Vital	ician: The lav certificate has rector, page 2	a	25. Was case referred to medical				26. Place	of Death	Check onl			
<u> </u>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1. ☐ Inpatient 2 ☐ E	R/Outpatie	MI 3 DOA				dence 6 Oth		
on of	ding Ph h. After th funeral	tion:	27. Manner of Death 1	(Month, Day Year)	28b. Time o Injury	Wo	ıryat ork?]Yes 2.∐1		d. Describe t	how injury occur	red	
Division	To the Hospital or Attanding Physician: The I within 24 hours after death. To tha Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could no determin	t be ago Blace of Injuny - At hom	ne, farm, s	treet, factory, office		28f	. Location (S City or Tox	Street and Numb wn, State)	per or Rural Route Numi	ber,
	Hospital 24 hours a Funaral etely filled	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my know xaminer: On the basis of examination	rledge, dea on and/or i	th occurred at the to	ime, date and opinion, deat	d place, and th occurred	d due to the at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	MChintonse of	FICE	7 "	150 59 19	85			d (Month, Day, Year)	
	10		6110 11111	ho completed cause of death (Item:	23a) (Type	p, Print)	, ele	N BL	RMIE	s = m	21061	
	St Regist	ate trar	31. Date filed (Month, Day, Year)	32, Registrar's Signatu 8 2005	Jre .	Sperte						

HLIWS

GRACE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 30 aM Judith Sweitzer 05 Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Baltimore Center Kosedale Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 20F Yrs. **Director** 217-54-8467 56 1/14/1949 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow injury or other traumatic evant, the Medical Evantrial must be notified at 1 ☐ Yes 2 XNo Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 2114 Oakland Road 21220 Α. "natural", or Itams 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💆 No Specify: ģ Specify: Sweitzer, Judith 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If itam 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Unknown) Cook Stillwell Helen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Sweitzer (Husband) 2114 Oakland Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 4/18 2005 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ney monia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1 Yes 2 DNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death.

Diractor: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one 29b. Signator and liftle of ce

29a. Certifier

Medical

29d. Date signed (Month, Day, Year)

30. Name ar who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, Md 21237 Hano well 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State APR 1 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year 2000 Sandra Christine Shaffer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Arundel Hospital Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec. 26,1949 Birthplace (State or Foreign Country)
 MD 1 M 2 QF Days Months Hours Yrs. 217-52-3036 55 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Lionsheart Glen 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: white 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rosswill Fear Alice Paradise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Lewis E. Shaffer/husband 306 Lionsheart Glen, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 4/14/2005 Glen Burnie, MD 21. Signature of Peral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1Schemic y ear c disease or condition resulting in death) oronory Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death

3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

attending physician

The law requires that the death certificate be executed

the Hospitel or Attending Physicien:

death.

in by the funeral director,

After

Director:

Division of Vital Records, P.O. Box 68760

Department o Importent: If any injury or once. ŏ

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumetic event, it a Madical Examinar , ust be retified at

Pages 1 and 2 should be t of Health and Mental

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Matural 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

within 24 hours a To the Funeral I

State Registrar 31. Date filed (Month, Day, Year)

APR 18

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Reginal Unknown				Type or Prin					•		_	
05-2489	9		1 - For Unpend Item Registrar	23a,27,28a	-f per m	e G842 Certificate	4-28 e of l	-05 tas Seath		Reg. No	2005	19101
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	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, 7	Town, or	Location of Death	1	40	. County of Deat	h
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7	Funeral			Sex 7. Ago 1.227M 2□F	e (In yrs. last birth UG Yı	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	lav Vaar	la- + Co	hplace (State or Foreign untry)
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	a-fst	ctor	M.D N/C		BAI	timore						1 Yes 2 □ No
	or 28	Director	10e. Street and Number		-	10f. Zip	Code	_		10g. C	itizen of What Co	untry?
	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or Items 23a or 28a-f show aumatic evant, It a Marcial Examiner must be notified at			N AVE		d	121	3			1.5.A	
	er de Items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decede	lent of Hi rify Cuba	spanic Origin? (Si n, Mexican, Puert	pecify Yes or N o Rican, etc.)	10-	 14. Race - Ame Black, White 	
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Maryland	d 2 should be filed within 72 ho th and Mental Hygiene. 77 is marked other than "natu traumatic evant, Ire Mcdeal		19a. Informant's Name/Relationship	(Type, Print)	196.7	~ ~	1/	and Number or Ru	0	ber, City	or Town, State, 2	Z1213
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	/Medical		resulting in death)	a	a consequence of		and	Oocarne	USE			
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n c	ding P h. After I funera	lon:	27. Manner of Death 1 □ Natural 5 □ Pending	Foundath, Day	^{y Year)} Four		8c. Injury Work		28d. Describe	how inju	iry occurred	unk
isi	vttendii death. ctor: A y the fu	icat	2 Accident investigate 3 Suicide Could not	7 7 05	2:15		1 🗆 Y	∕es 2 X No	28f Location	(Street a	nd Number or Ru	ral Route Number
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_	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	a C	29a. Certifier 1 ☐ Certifying P	hysicien: To the best			at the tim					stated.
	ne Ho 124 h na Fui	edical	(Check only 2 Medicel Execute)	miner: On the basis of and manner sta	examination and/	or investigation,	in my op	inion, death occur	rred at the time	, date an	d place, and due	to the cause(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Me	29b. Signature and title of certifier	1 /	1 (29c.	. License				ate signed (Month	• • • • • • • • • • • • • • • • • • • •
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_	1		30. Name and address of person who	completed cause of d	eath (Item 23a) (T				• •		01001	
01	K pen		31. Date filed (Month, Day, Year)	WII).	ar's Signature			treet Ba	Ltimore	, MD	21201	
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				State of Maryla	nd / Departm <i>Certific</i>			•	giene Reg. No.		
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	th with the 23a or 28 ust by rud	Funeral Director	10e. Street and Number 2022 Harlem	Ave.	1 Of.	Zip Code			10g. Citizen of 1	What Count	try?
020	72 hours after death with the Maryland natural', or items 23a or 28a-f show afcal Examiner must be reditied at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes,	ecedent of Hi specify Cuba s 2 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rad Bla Specify	ce - America ck, White, e v: B/a	
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land 2	filed Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Lloyd Thompsor)	DOMEST	IC	18. Mother's Na	ame (First, Middle,	Maiden Surnan	7e)	
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Place of Disposition (cometery, crematory)	or other plac atomy		Date 4-18-05 (20c. Location -	-	
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Division o	or Attending Physician: after death. Director: After this certific i in by the funeral director,		27. Manner of Death Natural 2. ☐ Accident 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury Work 1 ☐ Y	at ? ′es 2 □ No	28d. Describe h	ow injury occurr	ed	
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	To the Complex	Me	29b. Signature and title of certifier	2 M.		29c. License	number		29d. Date signed	(Month, D	ay, Year)
1	100		30. Name and address of person who co			w 5	_	altim	MI	7210	20/
	Sta Registr		31. Date filed (Month, Day, Year)	32. egistrar's Signa		0	,)	and the same			.,

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	/Medic Examin		4a. Facility Name (If not institution, g	ive street and numb				Location of	Death	4c. County		of Death		
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	Director		216 42 5977 Usual Residence of Decedent	1	63 Yrs	Months	Days	Hours	Min.	Date of Birth (Month, Day, Jan 14,	1942	Country Mary La	and	
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		neral	11. Marital Status 12. Was Decedent Evering 13. Was Decedent of Hispanic Origin? (Specify Yes Armed Forces? 1960 If Yes, specify Cuban, Mexican, Puerto Rican, et						fy Yes or No-	14. Race	- American	Indian,		
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene "neturel", or items 23e or 28e-1 show them 21 is marked other than "neturel", or items 22e or 28e-1 show other treumatic event. It Medical Examinating the mail th	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Field Engineer 16b. Kind of Business/Industry 16c. Kind of Business/Industry											
land 2		To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)											
			19a. Informant's Name/Relationship Gloria J. Smith	(Type, Print) (Wife)	19b. M	ailing Address 2508 Mc	(Street a	nd Number Driv	e, Br	Route Number, Candywii	city or Town, S ne, Mar	State, Zip Co y land	2061	3
ore,	ages 1 a. nt of Hea : If item or othe		20a. Method of Disposition 1 ☐ Burial 2 Aleremation 3		20b. Place of Di cemetery, o			1	Dat		20c. Location - 0			
Baltimore,	permit. Pages Department of H Importent: If ite any injury or of once.		21. Signature of Funeral Service Lice		Lee Cre	22. Name an	d Addres	s of Facility	Lee F	uneral	Clinton Home,In	nc 663	33 01	
Г	icate be executed Medical Examiner the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
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Records, P.O. Box 68760,		-												
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	death certifi e attending id for use as	tlon: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \ Yes 2 \ Nc 9 \ Unknown \ Nc 9 \ Unknown \ Nc Yes Nc Yes Yes								23d. Date of delivery Month Day Year			ear
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Vital	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag		25. Was case referred to medical examiner? Hospital: 37. Other										===	
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ì		Ž	29b. Signature and tyle of pertifier		MN		License		/ T 77 \	29	d. Date signed			_
10-	119		30. Name and address of person with				1012.		-	NAVAL I	A-PR MEDICAL			
10	Sta	te	31. Date filed (Month, Day, Year)		USN pistrar's Signature	1					89-5600			
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Sean Sebastian 05-2586 DOS

5-25 OS	586		1 - State Amend Ite Registrar	State of 2&Unpend	Marylan It em	nd/Depa 23a,27	artment 28a-f	of H	ealth a	G843	legtal Hy	gjene Reg. No.	s 2000	. 10100
	Physic		Decedent's Name (First, Middle SEAN					SEBASTIAN			2. Date of De Month	ath Day	Year 2005	3. Time of Deau
	/Medi Examir		4a. Facility Name (If not institution Laurel Regional	l Hospital	give street and number)		4b. City, Town, or Location of Deat Laure1				April	4c. (County of Dea	orges
	Funeral Director		5. Social Security Number 215-80-8220 Usual Residence of Decedent	6. Sex 7. 1 M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	If Under a	Min.	8. Date of Bir Month Da APR. 21	, 1973	9. Bir	thplace (State or Foreign D.C.
, ,	the Maryland 28a-1 show	Director	10a. State 10b. County	NTGOMERY BURTONSVILLE							10d. Inside City Limits 1 ☐ Yes 2 ☒ No			
	72 hours after death with "natural; or Itams 23a or circal Exam be must be		10e. Street and Number 3525 HEPBURN	COURT	12. Was Decedent Ever in U.S. Armed Forces?		10f. Zip Code 20866				10g. Citiz	en of What Co	USA	
980		by Funeral	11. Marital Status 1 □ Never Married 2 🛣 Mar 3 □ Widowed 4 □ Divorced	ried 1 Yes 2			. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:		gin? (Spe , Puerto	Specify Yes or No- no Rican, etc.) 14. Race - A Black, V Specify:		4. Race - Ame Black, Whit Specify:		
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Baltimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5	Specify)	ate c	Place of Dispo semetery, crer LEBA	natory or oth NON CE	er place MET	ERY)4/15		P	ation - City or	, MD
Ba	Depa Impo any ir		21. Signature of Funeral Service	- Kusia	and the deat	8	900 RE	EIST	ERSTO)WN F		PIKES		MD 21208
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	а.Торамах		ity	er the mode	or dying	, such as t	Jardiac C	or respiratory a	irest,		Approximate Interval Between Onset and Death
	Attending Physician: The law requires that the death certificate be executed or death. Tright. Standard. St	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a consequence of):									
8760,		dical Examiner	Cause Disease or injury that initiated events resulting in death) Last C											
P.O. Box 6		by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ∏ Fetai tat time of d	Ideath 3□	Ectopic pre					23	3d. Date of del Month	ivery Day Year
ords, P			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to							3.6				
Vital Records,		Completed								prior to completion of cause of				
	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 ↑ Yes 2 No	Hospital: 1 ☐ Inpa	atient 21	ER/Outpatien	t 3 DOA				n (Check only o		□Other (Spe	cify)
Division of	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation 4-12-0	Day Year) 5		P ^M	c. Injury Work 1 🔲 Y	at ? es 2 X	10	28d. Describe I	now injury	occurred	unk
Divi	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer.		4 Homicide determ	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Scene ring Physician: To the best of my knowledge, death occurred at the time, date and p			I	28f. Location (Street and Number or Rural Route Number, City or Town, State 3525 Hepburn Court Burtonsville, Md						
	the Hos nin 24 h tha Fur npletely	Medical	one)	and manner	s of examinal	tion and/or inv	estigation, in	n my opi	nion, deat	h occurre	ed at the time,	date and p	olace, and due	to the cause(s)
	with To	2	29b. Signature and title of certifie Za Li	Most	1er			OCI					signed (Monti	
			30. Name and address of person	who completed cause of	of death (Nem		11	1 Pe	enn S	tree	t Balt	imor	e, Mar	yland 21201
	Sta Registr	62	31. Date filed (Monta PR Yar)	8 2005 32.	istrar's Signa	turdy A	parte	,						

			4 101	eartment of Health and Men	, 0								
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer 3. Time of Death Month Day Yeer										
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ril 6	2005 4c. County of Death	3:42 a [™]						
			Millennium South River	Edgewater		Anne Arur	ndel						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 TF 90 Yrs.	Months Days Hours Min. Au	8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Aug. 27 1914 Marylan								
	pur &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ogation		140	1 1-11-05-11-11-						
	Aaryla F sho	ō				100	d. Inside City Limits 1 XYes 2 □ No						
	the 128a	Director	Maryland Anne Arundel Annapo 10e. Street and Number	10f. Zip Code	100	g. Citizen of What Countr							
	h with		42 College Creek Terrace	21401		USA							
	ems :	Funeral		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No-	14. Race - Americal Black, White, et							
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic avant, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:	, 0.0.,	Specify: B12							
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12	within ene. than "		Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)									
2	e filed v al Hygie othar t vant, Ib		6th 0 D	omestic 18. Mother's Name (First		Private Fa	ımily						
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ary	2 should be and Mental is markad is markad		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Rou	ute Number, C	City or Town, State, Zip C	Code)						
	1 and 2 Health am 27			Hicks Ave. Annapo									
Baltimore,	permit. Pages 1 Department of H Important: if ital any injury or ott		20a. Method of Disposition 1\textsup \textsup	ematory or other place) A Memorial		Oc. Location - City or Tow							
altir	permit. Departmimporta		21. Signature of Funeral Service Licensee 22. Name and Address of Facility										
<u> </u>	89 = 8		Zarry 1. Reese Moo483 Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401										
			23a. Part1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
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900	e taw requir has been si je 2 should	plet	Dementia Sick Sinus	Synchrome =	24a. Was an autopsy	sy findings available							
Vital Record		e Com	Pacemaker, Retrostornal	d? death?									
	Physician: this certificatal director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No										
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Division	ttendin death. stor: Af / the fur	atic	2 Accident investigation M 1 Yes 2 No										
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	To the Hospital or Attending Ph within 24 hours atter death. To the Funaral Director: After th completely filled in by the funeral	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Da	iy, Year)						
ŧ			Eyan - C. Surona.	D 50653		4/7/05							
6			30. Name and address of person who completed cause of death (Item 23a) (Type 5851 - Roale Claup Cla How Re		URAI	シャフロ							
Í	Sta		31. Date filed (Month, Day, Year) 32. Signature	1. N.	-	2014/							
	Registr	ar	APR 1 8 2005	2846									

			For Stata Registrar	State of Maryla		artment of H <i>tificate of L</i>		lental Hygie Reg.	4000	13109
	Physici		Decedent's Name (First, Middle, Last) RAMONA SUSAN	TOMASSE	TTI			2. Date of Death Month APRIL 15	Day Year	3. Time of Death 7:40A M
	/Medic Examin		4a. Facility Name (If not institution, give s				Location of Death	TARCE 15	4c. County of Dea	th
	Funeral Director		Social Security Number 6. Sex		rs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 4-11-195		thplace (State or Foreign ountry) RYLAND
	D		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo			4-11-155	· Mai	10d. Inside City Limits
	with the Maryland a or 28a-f show	Director	MD BALTI 10e. Street and Number	MORE		PERI	RY HALL	100	Citizen of What C	1 ☐ Yes 2 💢 No
	or death with the Marylar ttems 23a or 28a-f show armunt be notified at		5046 GLENSIDE MA			2	1128		U.S.	.A.
920	를 맞게	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 戊 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2፟ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
15-0	"natural",	eted	15. Decedent's Edu (Specify only highest grade	cation a completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of worki	ing 16t	o. Kind of Business	/Industry
212	be filed within 72 hours a Ital Hygiene. Id other then "natural", o evant, The Medical Exar	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)		DISABLED			DISABLE	ED
Maryland 21215-0036	2 should be filed v and Mental Hygie is marked other t aumatic evant, III	Be	17. Father's Name (First, Middle, Last) LOUIS JOHN	TOMASSETT	I		18. Mother's Name CLARA	(First, Middle, Mail DAMRO)		
laryl	s 1 and 2 should f Health and Men item 27 is marke other traumatic	은	19a. Informant's Name/Relationship (Type	*	19b. Mailin	ng Address (Street a	and Number or Rura	al Route Number, Ci	ity or Town, State,	Zip Code)
	1 and Health em 27 ther tr		ALESIA TOMASSETTI 20a. Method of Disposition	·	o. Place of Dispo	sition (Name of			RRY HALL,	
Baltimore,	mit. Pages partment of l cortent: If it injury or o		1 Durial 2 Cremation 3 R 1 Donation 5 Other (Specify)	emoval from State	cemetery, cren ULANEY V	natory or other place ALLEY MEN	4-16	6-2005 T	IMONIUM,	MD
Balt	permit. Departr Importe any ing		21. Signature of Funeral Service License	LE FUNERA ALE, MD	AL HOME 21237					
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the d	eath. Do not ent	er the mode of dyin		or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	11 le	ukem	IN/LY	uphon	<u> </u>	WEEKS
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68760,	be executed sician and burial-transit	al Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
	tificate ig physi as the l	ledical							1	
.O. Box	requires that the death certificate be executed eeen signed by the attending physician and hould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ybo 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
Δ.	w requires that the bear signed by should be detact	by	Part II. Other significant conditions cor	tributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac 1 ☐ Yes		o the cause of death?
of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s = 2 \(\square \) No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital: 1 Inpatient 2	2 ☐ ER/Outpatien	at 3 DOA Other	26. Place of Death	me 5 ☐ Residence	o Othor (Spr	acity Mestico
ion of	ding h. Aftel fune	ation; To	27. Manner of Death 1 Ratural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year		28c. Injun Worl		28d. Describe how i		sully) · Call
Division	or Attendant after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	kt home, farm, str ecify)	eet, factory, office	:	28f. Location (Stree City or Town, S		tural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by th	Medical C		sician: To the best of my ner: On the basis of exam and manner stated.						
	To the To the Comp	ž	29b. Signature and little of certifier			29c. Licens			Date signed (Mon	
	X		30. Name and address of person who co	impleted cause of death (Item 23a) (Type,	Print)	0 82 1	and feet an	o mo	750N
	Sta	ıt <u>e</u>	31. Date filed (Month, Day, Year)	32. degistrar's Si	gnature A	all's	8 31 12			
	Regist	ar	APR 1 8 20	105 Blown	N. 14					

04-15. 2005 (37:40AM

Temassetti, Ramova

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year James Edward Tracy 1302 PMApril 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 5+. Agnes

5. Social Security Number Healthcare If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/19/1958 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 ☐ F 215-80-0293 46 Director Washington D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 ie marked other than "naturei", or items 23e or 28e-f show treumatic event, the Madical Examinarinatival to notified at 10d. Inside City Limits 1 Yes 2 No Funeral Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1406-B N. Rolling Road 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Space Administration permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 ie marked othn any injury or other treumatic event ARR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Leech Tracy Dorothy Elizabeth Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sondra Waite - Wife 1406-B N. Rolling Road Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 04/19/2005 Baltimore, Maryland 21. Sonature of Funeral Service Lens 22. Name and Address of Facility d J. Weber Funeral Homes P.A. Edmondson Avenue Baltimore, Maryland 21229 ann 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subarachnoid Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any Judyn 15 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ en 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed? certificate l 2 No 1 ☐ Yes 2 No 1 ☐ Yes the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA P this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending 1 Tes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P16694 Midin Hired, M.D. 04/15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Mary land 21229 900 caton AVENUE Dr. Nudeem Ahmed

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 8 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 5
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 10,2005 **Physician** Thomas 20:15P M Mary Josephine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Southern Maryland Hospital Clinton George's | If Under 1 Year | If Under 24 Hrs. | S. Date of Birth | Months | Days | Hours | Min. | Sept 19, 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Year) 1920 1□M 2₩F Yrs. Director 217 36 6534 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or itams 23a or 28a-1 show other traumatic event, the Modical Executive to ust be notified at 1 Yes 2 No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 16301 Tanyard Road 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give X.A Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within the and Mental Hygiene.
7 Is markad other than " Elementary/Secondary (0-12) College (1-4or 5+) 7th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luckette Mark Windsor Rosa Birch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Thomas (SON) 16305 Tanyard Road, Upper Marlboro, MD 20772 Department of Health Important: If itam 27 20a. Method of Disposition

XXBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place) April 15, 2005
20c. Location - City or Town, State injury or Clinton, Maryland Resurrection Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 5633 013 21. Signature of Funeral Se Alexandria Ferry Road, Clinton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner burial-transit be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records. P.O. Box 68760. Physician/Medical IE FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown CARCINOMA METASTATIC Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Hospital or Attanding Physician: 24 hours after death. Funerel Diractor: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 2 and manner stated. To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) JOi3 216 11,2005 D40324 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 TERRY JODIZIE, M.D. 7503 SURRATTS ROAD, CLINTON, MAILYLAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 8 2005 Registrar

				partment of Health and Mental Hy ertificate of Death	giene 005 13112
	Physici	an	Decedent's Name (First, Middle, Last) Albert L. Vermette	2. Date of De	
>	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	12, 2005 4:45 P
	CAUIIII		Franklin Square Hospital Center	Rossville	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	y If Under 1 Year If Under 24 Hrs. 8. Date of Bir Months Days Hours Min. (Month, Da	th 9 Birthplace (State or Foreign
	Director		215-38-8858 TAXM 2DF 95 Yrs. Usual Residence of Decedent		15,1910 Maine
	yland how		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Ba-f s	Director	Maryland Baltimore	Parkville	1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ns 23	Funeral	8800 Walther Blvd. #4513 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No	United States 14. Race - American Indian.
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mantal Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumetic event, It's Madical Examitrational be notified at	by	Armed Forces? 1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ No 1 ▼ Widowed 4 □ Divorced Year or Dates: ₩₩II	. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ※☐ No Specify:	Black, White, etc. Specify: White
21215-0036	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation Be kind of work done during most of working	16b. Kind of Business/Industry
2	vithin ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
0 0	filed v Hygie other t	© Co	2 Years Chi	ef Warrant Officer 18. Mother's Name (First, Middle,	U. S. Army
Maryland	lid ba lantal kad o ic eve	To Be	Thomas Vermette	Delphine Cyr	
ary	2 should and Man is marka eumetic	j		ing Address (Street and Number or Rural Route Number	er, City or Town, State, Zip Code)
	and 2 ealth in 27 i			Magledt Road Baltimore,	Maryland 21234
altimore,	permit. Pages 1 and Department of Heall Importent: If item 2 eny injury or other office.		Tea bullar 2 Citerration 3 Chemoval nom States	osition (Name of parter) Con National Cem. 6/22/20	20c. Location - City or Town, State 5 Arlington, VA
Balt	permit. Departr Importe eny inji	ľ		22 Name and Address of Facility Uda-Ruck Funeral Home of 7922 Wise Ave. Dundalk,	
			23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardiac or respiratory an	rrest, Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):		Menths
E	Examiner				
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events c.		
, 0	icate be executed physician and s the burial-transit	Ехаг	that initiated events resulting in death) Last		
8760,	physic physic the br	dicai	d		
P.O. Box (The law requires that the death cartificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burfat-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	as that gned b	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
ord	w require been sig should b	ted	Prostate conv HTN	1 🗆 Y	res 2 □ No 3 □ Probably
Il Records,		Completed			
Vital	i ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of	
on of	ing Ph	ion: To	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	11 3 DOA 4 Nursing Home 5 Hesid	lence 6 ☐ Other (Specify) now injury occurred
Division of	after death after death Director: d in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		Street and Number or Rural Route Number, m, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the divestigation, in my opinion, death occurred at the time, of	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of centiler	29c. License number	29d. Date signed (Month, Day, Year)
			1	022111	April 13th 200,
10	115		30. Name and address of person who completed cause of death (Item 23a) (Type,	Blud Parkville	MD 21234
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registra	ar	APR 1 8 2005 Bleed It Room		

Patient Known as Valeric Wabb

Baltimore, Maryland 21215-0036 Division of Vital Records. P.O. Box 68760.

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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		For	State of Maryland / I	Department of F			_	
		for State Registrar		Certificate of		Reg. I	/11115	13113
Physici	an	Decedent's Name (First, Middle, Last	-	111		2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give	orani and number)	Webb	al austice of Dooth	11111	1th 2005	11:22pm
Examir	ner	Singi Hoso, L.1	of Baltimore	BH	r Location of Death		4c. County of Deat	¹ ル/パ
Funeral	_	5. Social Security Number 6. Se	7. Age (In yrs. last bit		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign
Director		Usual Residence of Decedent	M 2127 54	Yrs. Months Days	Hours Min.	April 5 /	951	MD MD
/land		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
Many e-f sh	ctor	MD	1	3/ Himor	U			1 485 2 No
or 28	Direc	10e. Street and Number	11 Apt a	10f. Zip Code		10g. (Citizen of What Co	untry?
eath w	erai	2510 Loyola Do	otheray	0	31215	***	U.	SH
ifter d	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of H If Yes, specify Cuba	/	lican, etc.)	14. Race - Ame Black, White	
should be filed within 72 hours after death with the Maryland and Maniel Hygiene. In arked other then "naturel", or items 23a or 28e-f show marked other then "naturel", or items 23a or 28e-f show metic event. The Medical Evantian mint be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify: B	lack
n 72 h "natu	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occup	during most of workin	g 16b.	Kind of Business/	ndustry
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ial y allo K 1 K should be filed with and Mental Hygiene. is marked other ther sumetic event, the M	Be C	17. Father's Name (First, Middle, Last)	1/		18. Mother's Name	(First, Middle, Maid	en Sumame)	
y can outd b Ments Marked Ments	To	Warnen	Havavir	rl	Jone.	Scott		
	W 3	19a. Informant's Nama/Relationship, (T)	pe, Print) 19b	. Mailing Address (Street	and Number or Rural	Route Number City	y or Town, State, 2	ip Code)
int. Pages 1 and 2 should be filed within 72 hours after death with the Marylan administ of the filed within 72 hours after death with the Marylan administ of Manial Hygiene. A structurelly or Items 23s or 28s-1 show injury or other treumetic event, the Medical Evantinal must be notified at injury or other treumetic event, the Medical Evantinal must be notified at 8.		20a. Method of Disposition	20b. Place o	f Disposition (Name of	Da PICAC	100/140/ ite 20c.	Location - City or	Town, State
Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ry, crematory or other place	1 4-27	-05 Y	3/1/2	mn
permit. Pages 1 and 2 Department of Health s Importent: If Item 27 is any injury or other tre once.		21. Signature of Filmeral Service Dicens		22. Name and Addres	of Facility		4140/1	8434
		Menod / V	arch	11/1/1/ 1230	Whotalley	Dr Jessus	PIPA	
Water Inc.		23a. P TT Enter the disease, or complete the control of the contro	cations that caused the death. Do not cause on each line.	not enter the mode of dyin	g, such as cardiac ir	respiratory arrest, *		Approximate Interval Between Onset and Death
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sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):	•			
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The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	icalE	l l	,					
rtificate ng phys	Medi	IF FEMALE:	•					
eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 manths?	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death				23d. Date of deli Month	very Day Year
by the a	Physician/Med	1 Yes 2 No 9 Unknown	4∏Pregnant at time of death 9☐ Unknown	5 Other (specify)			WOTE	Day Tour
res that igned by be deta	by Ph	Part II. Other significant conditions cor	tributing to death but not resulting ir	the underlying cause give	an in Part I.	23e. Did tobacco	use contribute to	the cause of death?
w require been sig should b		Congestive H	est Failure			1 🗆 Yes	2□No 3□Pro	bably 4. Unknown
e law r has be	Completed	Dights M.	-11,trs			24a. Was an autopsy	24b. Were au	opsy findings available ompletion of cause of
						performed?	death?	2 🗆 No
ysicien: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 🗷 ER/Ou	Othe	26. Place of Death			
9 € ± ½	h- 1	27. Manner of Death	28a. Date of Injury 28b. T	tpatient 3 DOA Time of piury 28c. Injury Work	4 Nursing Home	d. Describe how in		ity)
tending eath. or: After the funer	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Monor, Day Your)		Yes 2□No			
or Att	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28	f. Location (Street a City or Town, Sta		ral Route Number,
To the Hospital or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the fu	O	29a. Certifier 12 Certifying Phys	ician: To the best of my knowledge	, death occurred at the tim	e, date and place, an	d due to the cause	(s) and manner as	stated.
he Ho in 24 h he Fu pletely	edical	(Check only 2 Medical Exeminate)						
To t To t	Σ	29b. Signature and title of certifier	11 000	29c. License	number	29d. D	ate signed (Month	, Day, Year)
4		Chrose Xhl	at (Y).()	1)005	6338	Hp.	3/ 15+7	2005
5		30. Name and address of person who co	mpleted cause of death (Item 23a) (32. Degistrar's Signature	Type, Print)	Horntol.	£2.11		
Sta	_	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	1 . H. a	ع بدانور ا	109/17	mure	
Registr	ar	APR 1 8 20	05 Brown B.	Besie				

			1 - For State Registrar	State of Ma		partment of Certificate o		d Mental Hyg	iene 005	13114
	o c		1. Decedent's Name (First, Middle	Last)				2. Date of Deat	h	3. Time of Death
	Physic /Medi		Emma	Loui	se		Young	April	Day Year 13 200	M
	Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town	, or Location of D		4c. County of Dea	
			Laurel Region			Laur			Prince	George's
	Funeral Director			6. Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. last birtho 63 ^{Yrs}	Months Day		din. (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
			220-40-4260 Usual Residence of Decedent		0.5			07 17	41	MD
	show		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	e Ma	ctor	MD		Guilf	ord				1 □ Yes 2√2 No
	ith th	Funeral Director	10e. Street and Number			10f. Zip Code)	10	og. Citizen of What C	ountry?
	ath w	ra	9970 Gateway				20794		U.S.A	•
	ltems	une	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	Was Decedent o If Yes, specify Co	f Hispanic Origin? Jban, Mexican, Pt	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh	
336	Irs af	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	lf Yes XXX If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🛛 N	o Specify:		Specify:	Black
21215-0036	be filed within 72 hours after death with the Maryland tlat Hygiene. do othar than "natural", or items 23a or 28a-f show avant, I'm Mudical Evartingt must be rotified at	ted	15. Decedent	Education	16a. De	ecedent's Usual Occ	upation		16b. Kind of Business	s/Industry
215	hin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(G lit	ive kind of work don e. DO NOT use reti	ne during most of red)	working		duday
	filed withi Hygiene sthar than	Con	12th grade	na		ssembly	Tech.	N	orthrope	e & Grummar
nd	be file tal Hy d oth avant	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's I	Name (First, Middle, N	faiden Sumame)	
<u>y</u>		မ	Moses Owens					ice Huser		
Maryland	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationsh			ailing Address (Stre	et and Number or	Rural Route Number,	City or Town, State,	Zip Code)
Baltimore, I	es 1 an of Heal fitam 2 r other	l i	Mildred A. Ha 20a. Method of Disposition	_	20b. Place of Di	7 Harpe sposition (Name of crematory or other p	rs Farn	Road, C	olumbia,	vid 21045 Town, State
Ë	Pages ment of I tant: If it: jury or o	li s	XXBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp		Kina Me	emorial	Park 4	/19/05 R	andallst	own. Md
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	0	1	larch F/	H West	e, Baltim		
			23a. Part . Enter the disease, or o shock or heart failure. List of	omplications that caused	the death. Do not	enter the mode of d	ying, such as card	diac or respiratory arre	st,	Approximate
	Physician		Immediate Cause (Final disease or condition			y Arrest	_			Interval Between Onset and Death
4	/Medical		resulting in death)		a consequence of):		-			
	Examiner		Sequentially list conditions	b. Massiv	e Cereb	rouascu	lar Acc	ident		3 days
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87	physicate the l	dlcal		d	1115.25		8207			7.00
9 x	feath certific attending p	by Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					
Вох	atter atter I for L	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of de Month	livery Day Year
P.O.	that the d ed by the detached	ysi	1	9□ Unknown		o in our topoony)				
	requires that een signed b hould be deta	y PI	Part II. Other significant condition	s contributing to death bu	it not resulting in the	underlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	quire; n sig uld bi		Hypertension					1 🗆 Yes	2 No 3 P	obably 4 Unknown
00	> 10	Completed	Hyperlipidemia					24a. Was an	24b. Were au	utopsy findings available
æ	9 7 9	шо						 autopsy perform 	ed? prior to death?	completion of cause of
ta	10	a	Panhypopituita 25. Was case referred to medical	arism			26 Place of F	1 Yes 2	X No 1 Yes	2 No
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpat	ient 3 DOA	than	Home 5 Residen		cify)
J of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju		28d. Describe how		ony,
0	Attending r death. actor: After by the fune	atlo	2 Accident investiga	tion	.,,,		Yes 2 No			
Division	or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of Inju	ry - At home, farm, . (Specify)	street, factory, office)	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
Ω	urs af									
	To the Hospital or Attending Physician: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner stat	examination and/or	ath occurred at the investigation, in my	time, date and pla opini <mark>on, death</mark> oc	ice, and due to the cau ccurred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		0 0	29c. Licer	se number	290	d. Date signed (Mont	h, Day, Year)
			> Padmaj	a s. ilo	lapi n	D Ds	24174	4	-114109	
	1		30. Name and address of person w	no completed cause of de	ath (Item 23a) (Typ					
	. /		Padmaja Udapi,	MD 7350	Van Dus	en Røad.	Suite	#380, La	urel, Mo	20707
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signature	1 Proven				

3			For State Registrar		S	State of	Maryl	and / Dep <i>Ce</i>	artmen <i>rtificat</i>				lental		ene 2 0	05	13115
	D		1. Decedent's Nan	ne (First, Midd	e, Last)				2. Date of Death Month								3. Time of Death
	Physic /Medi		JENNIF	ER ADAN	ſS								Apr		Day 2005	Year	7.59 P M
	Exami		4a. Facility Name				ber)		4b. City,	Town, or	Location of	of Death			4c. Count	y of Deat	h
				sity H	-				-	ltimo							
	Funeral		5. Social Security I		6. Sex 1 ☐ M	2 F 7		yrs. last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.		of Birth h, Day, Y		9. Birtl	hplace (State or Foreign nuntry)
	Director		458.59. Usual Residence			XX		22					MAY	28,1	982		TX
	yianc how		10a. State	10b. County			10c.	. City, Town or Le	ocation								10d. Inside City Limits
	a Mar	Director	MD	HOWAF	D		SA	AVAGE									1 Tes 2 No
	or 28)ire	10e. Street and Nu	ımber					10f. Zip	Code				10g	. Citizen of	What Co	
	death with the Maryland me 23a or 28a-f show r must be notified at	rall	8546 ST	ORCHWOO	D DR	APT.	2A		207	63					U	SA	
	er de itemé	Funeral	11. Marital Status			Was Deced Armed Forc	es?	in U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes o Rican, etc	or No-		ice - Ame ack, White	ncan Indian, e, etc.
36	rs aft	by F	1 Never Mar 3 Widowed			If Yes, Give Year or Date	es.		1 🗆 Yes 📑		Specify:				Speci		
9	within 72 hours after ene. than "neturel", or ite he Medical Exertire			15. Deceder	t's Educati	on		16a. Dece	dent's Usua	X al Occupa	ation			16	b. Kind of E		HITE Industry
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7	filed with Hygiene other tha	Con	12					ANAL	YSIS	TECH	NICIA	N			US NA	VY	
nd	be filed within 72 hours after death with the Manylan ntal Hygiene. at other then "neturelt, or iteme 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name								18. Mothe	r's Name	First, M.	iddle, Ma	iden Suma	me)	
Z Sagar	2 should be filed within and Mental Hygiene. Is marked other than eumstic event, the M	ို	JOSEPH 1												LBERT		
Maryland 21215-0036	d 2 st th and th and 17 is n		JOSEPH A			FAT	HEB								ity or Town		ïp Code)
	Heal Heal tem 2		20a. Method of Dis					b. Place of Dispo	sition (Nan	ne of			OLII				Town, State
Baltimore,	Pages ment of ent: If i		Burial 2	☐ Cremation 5 ☐ Other (S	3 □Rem	oval from St	ate	cemetery, cre PINE CRE	natory or o	ther place		4.17	.200		ATLAN		
Balt	permit. Pages I and 2 should be Department of Health and Menla Importent: if Item 27 is marked any injury or other treumatic evonce.	1	21. Signal of F	uneral Service COXY F	-	MO		F	Name an	d Addres	s of Facilit	ME,	P.A.			53	
			23a. Part1 Enter		-		1148 used the d	leath. Do not ent	er the mod	A I N le of dying	g, such as	cardiac o	r respirate	UKNLI ory arrest	E, MD	2106	Approximate
	Physician		fmmediate Cause disease or condition	(Final	or y one o	M. F	11 1010.	1.	-								fnterval Between Onset and Death
	/Medical		resulting in death)		a	Due to (or	as a cons	sequence of):	1163								
н	Examiner		Sequentially list co	onditions,	b												
	ed sit	ine	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Į	Due to (or	as a cons	sequence of):									
	xecut and	Examiner	that initiated event resulting in death)	5	c	Due to (or	as a cons	sequence of):									
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.89	tificate ng phys as the	edical			u												
Вох	ndir use	M/UK	IF FEMALE: 23b. Was deceden			If yes, outco 1 ☐ Live birth			Ectopic pri	0=00001					23d. Da	ate of deli	very
	e death he atte	Physician/N	in the past 12	□ No		4□Pregnan 9□Unknow	nt at time o		Other (sp						Mi	onth	Day Year
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	ires the signeral be d	þ	Part II. Other signi	iicant conditi	ontrio	uting to deat	in but not	resulting in the u	nderlying ca	ause give	n in Part I.				co use con	itribute to 3 □ Pro	the cause of death?
Ö	w requir been si should	etec													2 LI NO	3 🗆 🗀	Daoly 4 Conknown
Records,	e la has	Completed												Was an autopsy performed		Were aut prior to c death?	topsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	e Co	25. Was case refer	red to modical									1 X (1)	es 2		1 y es	2 No
>		OB	examiner?		Hosp	ital: 1 🕅 Ino	atient 2	ER/Outpatien	t 3 DQ	Othe	26. Place				e 6 □Ott	nor /6-00	
J Of		盲	27. Manner of Deat		2	8a. Date of i		28b. Time of		8c. Injury Work	at				iniury occu	rred .	
ioi	Attending r death. sctor: After	atlo	1 □ Natural 2 □ Accident	5 Pendin investig	ation 4	the5	Day roan,	2 3 o	М		es 2 1	No ,	الماليان	pudy !	· //	will	bywhich
Division	l or Att after de Direct	Certification:	3 🗍 Suicide 4 🔲 Homicide	6 🗌 Could i determ		8e. Place of building	, etc. (Spe		eet, factory	, office	1		281. Locati City o	r Town. S	itate) L	ber or Ru	ral Route Number,
	Hospitel 24 hours a Funerel I tely filled	edical C	29a. Certifier (Check only	1 Certifyin	g Physicia Examiner:	n: To the be	est of my k	knowledge, death ination and/or in	occurred a	at the time	e, date and	d place a	and due to	the caus	e(s) and m	anner as	stated.
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medi	29b. Signature and			and manner	stated.			. License							n, Day, Year)
			Th.	du .	11	1. or		2		OCM	ਧ			Λ	ril 1	1 0	005
	51		30. Name and addr	ess of person	who compl	eted cause	of death (I	tem 23a) (Type,	Print)					1	ril 1	,	
_			THEUDO.	re u.	cong				1	TT B	enn S	tree	et B	a⊥tiı	more,	Mary	yland 21201
	Sta Registr	43	31. Date filed (Mon	APR I	9 200	32. Feg	istrar's Sig	gnature A	medi	P							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** rson ,2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis

5. Social Security Number Himore nda nwo 9. Birthplace (State or Foreign 8. Date of Birth Month, Day 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1□M 20 F Months Hours -30-3124 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Completed by Funeral Director Maryland altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be illiam P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - 1 Srown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility Barto. Home th Ave. 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail fre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) N802 05 26 co 2 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 mon Month Day Vear 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 🗌 Yes 3 Probably 4 □Unknown Be Completed 0 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nersing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending

Priysician /Medical Examiner the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed as for use P.0. Division of Vital Records,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ont: If Item 27 is marked other than "natural", or Items 23e or 28e-f show

Baltimore, Maryland 21215-0036

other treumatic event, it a Medical Examiner must be notilised at

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יפות בעופלנט: Atter this certificate has been signed by the : filled in by the funeral director, page 2 should be detached Certification: To

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

State Registrar 28c. Injury at Work? 1 🔲 Yəs 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

4000 OLD COURT

29d. Date signed (Month, Day, Year)

ICESUILLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PNICK

APR 1 9 2005

investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the

			1 - For State Registrar	State of Maryland	d / Department of Health and It Certificate of Death		ZUUS	13117
			Decedent's Name (First, Middle, Last)	Commodity of Bodin	2. Date of Death		3. Time of Death
	Physici /Medio		Richard	R. Ander	rson SR		5 2005	2:45 P.M
}	Examir	er	4a. Facility Name (If not institution, give	100.11 0 1	4b. City, Town, or Location of Death		4c. County of Death	1
	Funeral		5. Social Security Number 6. Se	t, 7. Age (In yrs. la	ast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Hartora 9. Birth	place (State or Foreign ntry)
	Director		ald - 30-64511	(M 2□F	7 Yrs. Months Days Hours Min.	(Month, Day, Yea	7 MA	RYLAND
	land ow		Usual Residence of Decedent 1 10a. State 10b. County	10c. City,	, Town or Location		1	10d. Inside City Limits
	Mary a-f sh	ţor	MD HARFO	RO	Forest Hill			1 □ Yes 2 No
	or 284	Director	10e. Street and Number	21	10f. Zip Code	10g. (Citizen of What Cou	ntry?
	eath w	eral	1924 Phillips	12. Was Decedent Ever in U.S	J. 21050	anaita Van au Na	USA	an Indian
co.	ofter de	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	14. Race - Ameri Black, White,	
003	ural', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	rite
15	in 72 l	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/In	dustry
212	d with giene.	omb	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesman	2	elf En	played
nd	be file tal Hy d othe svent,	Be	17. Father's Name (First, Middle, Last)	1	18. Mother's Nam	ne (First, Middle, Maid	en Sumame)	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svent, the Medical Evanfrar must be notified at	은	JOHN J. H 19a. Informant's Name/Relationship (T)	nder son	19b. Mailing Address (Street and Number or Ru	Man S	ONC.	2 Code)
	カモアヤ		Λ Ι	on-wife	1924 Phillips Mill	Rd. For	5+ H. II	MD 21050
altimore,	permit. Pages 1 am Department of Heali Importent: If itam 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b. Pla	ace of Disposition (Name of metery, crematory or other place)	Date 20c.	Location - City or To	
Ē	permit. Pages Department of I Importent: If it any injury or o		`4 □Donation 5 □ Other (Specify)	ran	Kuxood Cenetery 4-		ARKUILL	= MD
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service locens	20 1	22. Name and Address of Ficility	mD 212		24.0 0.0
			23a. Part 1. Enter the disease, or compl	regions that caused the death.	Do not enter the mode of dying, such as cardiac		POD HARF	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	aCONSESTIME	No + 5 1 2			Onset and Death
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		e	Sequentially list conditions,	Die to (or as a consign	ence of):			1003
V	outed id ansit	Examiner	Many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	, , , , , , , , , , , , , , , , , , ,			
ŠÓ,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):			
8760	The faw requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		1.				
Box	leath certific attending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan			23d. Date of delive	ary
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal of 4 Pregnant at time of dea			Month	Day Year
J.	hat the de ad by the a detached	Physic	9 Unknown		Iting in the underlying cause given in Part I.	23e Did tobacc	o use contribute to t	he cause of death?
ecords,	luires that n signed t	d by	-	INSUFFICIENCY	, and the state of			pably 4 Unknown
O O O	aw require is been sig 2 should b	Completed				24a. Was an	24b. Were auto	psy findings available
r		Com				autopsy performed? 1 Yes 2 D	death?	mpletion of cause of 2□ No
Vital	ician: certific rector,	Be	25. Was case referred to medical examiner?	fospital:	Othor	th (Check only one)		
o	y Phys er this eral di	n: To	27. Manner of eath	1 □ Inpatient 2 □ E	28b. Time of 28c. Injury at	ome 5 A Residence 28d. Describe how in		y)
ion	ending sath. or: Afte	atio	Natural 5 Pending investigation	(Month, Day Year)	Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	or Atta	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,
_	spital or Attending Pi hours after death. nerel Director: After th y filled in by the funera	O	29a. Certifier 12 Certifying Phy.	sician: To the best of my know	rledge, death occurred at the time, date and place,	and due to the cause	(s) and manner as s	tated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occur	rred at the time, date a	and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1	29c. License number	29d. [Date signed (Month,	Day, Year)
			7 / Cin 8	· Cerry	076271	4	/18/05	
	17		30. Name and address of person who co	Cove w	23a) (Type, Print) 7602 Belgin R	& An It	mer, m	1 21286
	Sta	-	31. Date filed (Month, Day, Year)	33. Registrar's Signatu	ire franks			
	Registr	ar	APR 1 9 200	tilder D	19			

1.	Maryland / Department of Health and Mental F Certificate of Death	ygiene 005 3 8
Fraincest Frai		Death 3. Time of Death
Second Security Numbers Secu	77	
Directory Display Dis	per) 4b. City, Town, or Location of Death	4c. County of Death
The part of the pa	Months Days Hours Min. (Month,	olarh year) 9. Birthplace (State or Foreign Country) MD
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bactaniner and the death of the dea		
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bactaniner and the death of the dea	20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
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Due to (or as a consequence of):	sed the death. Do not enter the mode of dying, such as cardiac or respirator h line.	arrest, Approximate Interval Between Onset and Death
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SPJOO STATE OF THE PROPERTY OF		
Spaning of the part of the par	as a consequence of).	
So	me of pregnancy	23d Date of delivery
So	t at time of death 5 Other (specify)	
24a. Was an autopsy finding prior to completion of death? 1 Yes 2 No 1 Yes 2		2.7
The second secon		
	31	
25. Was case referred to medical examiner? 1	at pp 1	formed? death? 2 No 1 Yes 2 No
27. Manner of Death 28a. Date of Injury 1 Natural 28b. Time of Injury at Work? 1 Natural 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 38b. Time of Inju	pe 1 □ Ye 26. Place of Death <i>(Check on</i>	formed? death? 2No 1 Yes 2 No one)
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State Registrar 31. Date filed (Month, Day, Year) 22. Registrar's Signature	26. Place of Death (Check on Attent 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nursing Home 6	death? 2 No 1 Yes 2 No one) sidence 6 Other (Specify) how injury occurred (Street and Number or Rural Route Number, own, State) e cause(s) and manner as stated. I, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 4 15 2005

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death											
				Last)					:		h	Vand	3. Time of Death	n
	Physici /Medio		Joan Beni	1ett						April	13	2005	11:15 M	М
	Examin		4a. Facility Name (If not institution,		oer)		4b. City, Town			·	4c. C	ounty of Death	2/2	
	Funeral			pital S.Sex 7.	. Age (In yrs.	last birthday)	If Under 1 Yea	IN UNC		8. Date of Birth		9. Birtho	n/a	aian
	Funeral Director		219-32-5199	1 □ M 2X2NF	68	Yrs.	Months Day	s Hours	Min.	8. Date of Birth (Month, Day, 06/26)	Year) 11936	Cour	MD	- Gar
	D		Usual Residence of Decedent 10a, State 10b, County		10a Cib	y, Town or Lo	eation							
	Aaryla r sho	ō	MD	N7 / 7	100. 010	y, rown or Lo						'	0d. Inside City Lim 1 ☐ Yes 2 ☐ I	
	28a-	Director	10e. Street and Number	N/A			10f. Zip Code	altimo	re	1	0g. Citize	n of What Cour		
	h with		1709 Byrd Str	eet				21230				USA	rice .	
	ems (Funerai	11. Marital Status	12. Was Decede		.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Ori	igin? (Spec	city Yes or No-	14	Race - Amend Black, White,		
36	d within 72 hours after death with the Maryland jiene. I then naturel; or items 23s or 28s-f show the Mudical Examenarium be colling at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🛱 Widowed 4 ☐ Divorced	d 1 Tes 2	™ No		1 ☐ Yes 2 ☑ N				S		ite	
9	hour sul Ex		15. Decedent's	Year or Date	es: 	16a Decer	dent's Usual Occ	unation			16b Kind	of Business/In-		
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Maryland 21215-0036	ges 1 and 2 should to f Health and Men If Item 27 is marke or other treumatic		Joan Rodrig		hter		9 Byrd						C000)	
re,	es 1 and 2 of Health a of Item 27 is r other tre		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other p		Da			tion - City or To	wn, State	
imo	Page nent c ant: If ury or		¹X☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	ecify)	ate Gle	n Have	n Cem.		15,	2005	Gle	n Burni	e MD	
Baltimore,	permit. Pages of Department of Hamportent: If Ite any injury or of once.	21. Signature of Funaçal Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral H 1501 E. Fort Ave., Baltimore										e, Inc.		
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8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	dicai	•	d										
9	leath certific attending p	/Mec	IF FEMALE:	23c. If yes, outco	me of pregna	nev					1			
Вох	atten atten I for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Live birt!	h 2 ∏Fetal It at time of de	Ideath 3□	Ectopic pregnan Other (specify)	су			230	d. Date of delive Month	ry Day Year	
P.O.	that the deed by the detached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknow										
	The law requires that ate has been signed b page 2 should be deta	by P	Part II. Other significant condition				4 .			23e. Did tob	acco use	contribute to th	e cause of death?	
ord	w require	ted	Chrmic obst	ructive	pulm	unari	a isea	15		1 ☐ Ye	s 2 🗆 l	No 3 Prob	ably 4 □Unknov	ΝΠ
ec	e law I has be	Completed								24a. Was ar autops	/	prior to cor	osy findings availat npletion of cause o	ole of
E F										perform 1 Yes 2	No	death? 1 ☐ Yes	2 No	
Vit		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inp		FD/0-4		\thor		Check only one		70" '0 "		_
of	g Phys er this eral di	\vdash	27. Manner of Death	28a. Date of I (Month,		ER/Outpatien 28b. Time of	28c. In	ury at	-	e 5 ∐ Heside 3d. Describe ho		Other (Specify	")	
ion	Attending F r death. sctor: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury		ork? ⊒Yes 2⊟i	No					
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of building	Injury - At ho , etc. (Specify	ome, farm, str	eet, factory, office	9	28	f. Location (Str City or Town	eet and N State)	Number or Rura	l Route Number.	
	ortel or afforms affor													
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the be caminer: On the basi and manner	is of examinat	wledge, death tion and/or inv	occurred at the restigation, in my	time, date an opinion, dea	d place, an th occurred	d due to the ca d at the time, da	use(s) an ite and pl	id manner as st ace, and due to	ated. the cause(s)	
	vithin Fo the	Me	29b. Signature and title of certifier	4				nse number				igned (Month, i		
)			MGi Can	ti MI			RE	500	1	1	tori	1 13	2005	
	10		30. Name and address of rson w	to Hark	our H.	Spila	Print) 300	i S.H.	ZINOVE	er St.	Bal	timere, M	2005 212; laryland	25
	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ture				<u> </u>				
	Registr													

William Biggs 05-02580 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

258	30		. For	ene) n	OE	10100					
			1 - State Registrar			rtificate of			, No.	UU	13120
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death	Devi	V	3. Time of Death
	Physici /Medio		William H	<u> </u>				April	12	2005	8:57 P ^M
	Examin	er	4a. Facility Name (If not institution,				or Location of Death		4c. County	y of Death	
			Johns Hopkins B			Balti				N/A	
	Funeral Director		5. Social Security Number 216–82–3919	6. Sex 7. A 1 → M 2 □ F	ge (In yrs. last birthday) 44 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 09/04/19	960	9. Birthp Coun	lace (State or Foreigr try) MD
	g ,		Usual Residence of Decedent		10c. City, Town or Lo					1	0d. Inside City Limits
	Maryla of shov	tor	10a. State 10b. County	N/A	Toc. City, Town of Ec	Baltin	ore				1 ☐ Yes 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene. I have 15 is marked other then "natural", or Items 23a or 28e-f show other treumstic event, the Medical Examinar must be multified at	Funeral Director	10e. Street and Number 1705 Clarkson	Street		10f. Zip Code	21230		j. Citizen of		itry? JSA
9	after deatl or Items 2	Funera	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Armed Forces 1 Yes 2 X	? DMp	If Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, e	etc.
8	ral', c	l by	3 ☐ Widowed 4 ☑ Rivorced	If Yes, Give Year or Dates:		1∐ Yes 2 🔀 💥 o	Specify:		Specif	y: 	white
21215-0036	nin 72 ho In "natur Medical	Completed	15. Decedent's (Specify only highest	s Education grade completed) College (1-4or	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing 16	b. Kind of B	Business/Inc	dustry
212	filed within Hygiene. other than "ent, the Max	E O	Elementary/Secondary (0-12)	0		Leed Serv	rice Atten	dant	Am	track	
	ould be file Mental Hy tarked othe	To Be C	17. Father's Name (First, Middle, L William H. Bi					(First, Middle, Ma llis B. S			
Maryland	d 2 should be th and Mental 7 Is marked of treumatic ev	H	19a. Informant's Name/Relationsh Virginia L. H	al Route Number, C Baltimo							
	is 1 and 2 of Health item 27 I		20a. Method of Disposition	c. Location							
altimore,	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (Sp	ecify)	BayView C	matory or other pla	04/2		Baltim		
Balt	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Eunoral Service L	Funeral nue Balti	Home, more	Inc. Maryla	and 21230				
	Physician /Medical	e l	23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a.	d the death. Do not entitle.	. /	ng, such as cardiac o	,			Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence of):	1 3 2 2					
V	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ć	execut an an ial-tr	Еха	resulting in death) Last	Due to (or as	s a consequence of):						
68760,	icate be executed physician and s the burial-transit	dicai		d							
O. Box	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ite of delive	ry Day Year
s, P	quires that I in signed by uld be deta	þ	Part II. Other significant condition	A Cofol A	but not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did tobac	2 No	tribute to th	e cause of death? ably 4 Unknown
Vital Record	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	d?	prior to con death?	osy findings available npletion of cause of 2 No
ita		o o	25. Was case referred to medical				26. Place of Death	(Check only one)			
>	ysicien: s certific director,	0 8	examiner? 1X2 Yes 2 □ No	Hospital: 1 ☐ Inpat	ient 2 ER/Outpatier	nt 3 DOA Ott	ner: 4 Nursing Ho	me 5 🗆 Residend	e 6 □Oth	ner (Specify	r)

To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director; After this completely filled in by the funeral directors and the funeral directions. Division of

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

28c. Injury at Work?

OCME

1 ☐ Yes 2 ☐ No

ess of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

111 Penn Street Baltimore, Maryland 21201

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

April 13, 2005

State Registrar

Certification:

27. Manner of Death 1 Natural 2 Accident

3 🗌 Suicide

4 Homicide

31. Date filed (Month, Day, Year) APR 1 9 2005

LARON LO

5 Pending investigation

6 Could not be determined

2. Registrar's Signature

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. **Physician** PU 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7. Age (In yrt. last birthday) JOSEPH 5. Social Security Number MOTE If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Yaruland Funeral 6. Sex Days Months Min. -52-9058 1 MM 2 ☐ F Yrs. Director Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumetic event, the Modical Examiner - ust be nutified at 1 Yes 2 □ No Completed by Funeral Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e ombe 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ō 1 ☐ Yes 2XNo Specify: Specify: 3 Widowed 4 Divorced t of Health and Mental Hygiene. If item 27 is marked other then "netural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) rogrammer 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James 19a. Informant's Name/Relationship (Type, Print) Brotler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an 52524 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Importent: If injury `4 Donation 5 Other (Specify) torest Son Name and Address of Facility
OSEPH L. RUSS of Funeral Service Gensee any ir Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner P.O. Box 68760,4 Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death. Director: After this certificate has I autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 TYAS Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 2 No Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

egistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rachellevine JHBMC 4940 Easte

APR 1 9 2005

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryl		artment of H			ene 2 0 0	5 13122
	Physici	an	Decedent's Name (First, Middle, Last)	0 (2. Date of Death Month	Day Yea	3. Time of Death
	/Media		KOBERT . C.	Berker	Bile			APRIL 15		
7	Examir	ner	4a. Facility Name (If not institution, give si			1.	Location of Death		4c. County of De	
			MARYIAND MASON I 5. Social Security Number 6. Sex	c Home	un (not birth do.)	If Under 1 Year	If Under 24 Hrs.	0.00 (0.00		Thore
п	Funeral Director			M 2□F 7. Age (///)	yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day,	1916 9.E	irthplace (State or Foreign Country)
			Usual Residence of Decedent					Dec 21,	1716	/ 7.
	rylan how		10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits
	8a-1 s	Sto	MO HOWA	r()		CoLui	nBIA			1 Yes 2 No
	vith th	Dire	10e. Street and Number	5 WAN W		10f. Zip Code		10	g. Citizen of What	•
	ours after death with the Marylar ral', or items 23a or 28a-1 show Examitmer must be notified at	rai					1045			A.
	iter dea	Š	11. Marital Status 1 1 □ Never Married 2 □ Married	 Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ ★6 	n U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black, W	nerican Indian, nite, etc.
936	urs al	by	_3☐Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2☐ No	Specify:		Specify:	uhite
21215-0036		Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occupa	ation	10	6b. Kind of Busines	ss/Industry
2	ithin.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			
	be filed within 72 ho ital Hygiene. d other than "netun event, tre Maulcal		12+4	NA		CABINET	- MAKEA			vesnment.
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ē,	s 1 and 3 if Health item 27 other to		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of natory or other place	WANTER	Date 20	Oc. Location - City	0 21045 or Town, State
Ę	Pages nent of int: If it		Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			F FAI+6		105	Balto. N	AD.
Baltimore,	permit. Pages Department of H Importent: If its any injury or of		21. Signature of Funeral Service Licenses		22	. Name and Addres				
m		. 13	Vaul M. S.	tella	75	ARTICUMINI	no RD.	BALto. A	W 21234	/
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	Enysician		Immediate Cause (Final disease or condition	End 91	tage D	enertu	`			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):		2			
	LXUIIIIII	ë	Sequentially list conditions, b.	Due to (or as a con-	clowto	i Vasan	len Do	euse		
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Box	eath certific attending p	an/A	230. Was decedent prognant	c. If yes, outcome of pre 1□Live birth 2□F		Ectopic pregnancy			23d. Date of d	
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Division of Vital Records,			25. Was case referred to medical					1 ☐ Yes 2√	2No 1□Ye	
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0	g Ph terthi		27. Manner of Death	28a. Date of Injury (Month, Day Year		28c. Injury Work		28d. Describe how		ouny)
Ö	death. ctor: Af the fur	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 car) Injury		es 2 □No			
ž	l or Att after de Direct d in by t	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
Ω	urs af urs af ral D						1			
	To the Hospitel or Attending Physician: within 24 hours after deals within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my lar: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
	othe othe	Me	29b. Signature and title of certifier	and manner stated.		29c. License	number	290	I. Date signed (Mor	nth, Day, Year)
	->-0		Pt fort	Sims.		72	1460		4/17105	
	0		30. Name and address of derson who com	pleted cause of death (I	tem 23a) (Type, I	Print)	7704		11/10	
_			ROBERT LIBERTO	mo. 352	8 BAN	k St	BALD,	my :	21224	
	Sta		31. Date filed (Month, Day, Year) APR 1 9 20	32. Fistrar's Signature	gnature					
	Registra	ar	חוע ד א לח	US platine	15 19	A CONTRACTOR OF THE PARTY OF TH				

			For State Registrar		State o	f Maryl	and	-	rtmen tificate				ental Hy	/giene	00)	13	23
	Physici	an	1. Decedent's Name (First, M			_							2. Date of Do Month	eath Day	Ye		3. Time (of Death
	/Medic		Erma 4a. Fecility Name (If not institu		Bower			/	4b. City,	Town, or	Location	of Death	Apr	4c. (County of E	05 Peath	21.	> //
	Lxaiiiii		Franklin:	Squa	re f	tospi	Ita			7	40 Se	da	le		Balt	IM	one	
	Funeral Director		5. Social Security Number 199 07 9173	6. Sex 1 □	M 251F	7. Age (In)	<i>yr</i> s. <i>l</i> a 90	st birthday). Yrs.	If Under Months	1 Year Days	If Under Hours	Min	8. Date of Bi (Month, D. Aug. 6	av. Year)		Birthpla Count PA	ace (State ry)	or Foreign
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	death with the Maryland rms 23e or 28e-f show	ō	MD 10a. State 10b. Cou	•	imore		. City,		ddle	Ri	ver							2 XNo
	r 28e-	lrect	10e. Street and Number						10f. Zip					10g. Citiz	en of Wha	t Count	ry?	
M	ath wit	ralD	10 Congres							212				USA			. 1 . 6 .	
12 M	s after	by Funeral Director	11. Marital Status 1 ☼Never Married 2 ☐ F 3 ☐ Widowed 4 ☐ Divor	Married	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	rces? 2 <mark>⊠</mark> No ∕e	in U.S	1	Vas Deced Yes, spec				cify Yes or Na Rican, etc.)		4. Race - A Black, V Specif W h	Vhite, e	tc.	
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Z 2	illed v Hygie other i	Be Co	12th 17. Father's Name (First, Midd	dle, Last)							18. Mothe	er's Name	(First, Middle	a, Maiden S	Sumame)			
No 15	Mental Mental arked o	To B	Daniel U.	Bowe	rs							na B						
Mar	d 2 shoul th and M 7 Is mari traumati		19a. Informant's Name/Relati Betty Riden			or				· .			Route Numb n Ter					MD
re,	s 1 and if Health item 27 other tr		20a. Method of Disposition		-	20	CAL	ice of Dispo	sition (Nam	ne of	e)	Da	ate	20c. Loc	ation - City	or Tov	vn, State	
$\mathcal{B}_{\mathcal{O}_{\ell}}$	permit. Page Department o Important: If any injury or once.		1X Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		Removal from	State	Eas	tHar:	risb	urg		4/19			Harr		_	
Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a MARA.		21. Signature of Funeral Serv	ry	Con	nel	le	1	300	U Ma	ice /	Ave.	nelly Balt	imor	ralH e MD	ome 21	ofEs 221	sex
			23a. Part1. Enter the disease shock, or heart failure.	or compli List only or	ications that c	aused the d	death.	Do not ente	er the mode	e of dyin	g, such as	cardiac or	respiratory a	arrest,			Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	Due to	O Cal	Y G	la!		n +	Oly	CTI	on					
	Examiner		Sequentially list conditions)													
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8760,	ate be hysicia the bur	dical			1											-		
9	ath certific attending pl for use as t	/Mec	IF FEMALE:	2	3c. If yes, out	come of pre	egnan	су						23	3d. Date of	deliver	~	
P.O. Box	the Hospitel or Attending Physicien: The law requires that the death certificate be executed hin 24 hours after death. the Funerel Director: After this certificate has been signed by the attending physician and the Funerel Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live b	oirth 2 F ant at time	Fetal c	leath 3 ☐	Ectopic pre Other (spe						Month		Óay 	Year
rds, P	w requires that been signed I should be det	by	Part II. Other significant con-	ditions cor	ntributing to de	eath but not	result	ting in the ur	derlying ca	ause give	en in Part I	•		tobacco us Yes 2		e to the		death? Unknown
oco	ne law requi	Completed											24a. Was	s an	24b. Were prior deat	autop to com	sy findings	available cause of
<u>a</u>	icien: The I certificate ha rector, page						_						1 ☐ Yes	2 No	deat	n? Yes 2	2□ No	
V.	ysicien: is certific director,	To Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☒ No		lospital: 1 171	Inpatient :	2 □ E	R/Outpatien	3 DO	A Othe	05		(Check only e 5 ☐ Res		Other (5	Specify)	
Division of Vital Records,	iding Phy th. : After this ; funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Per	nding estigation		of Injury th, Day Yea		28b. Time of Injury		8c. Injury Work		28	Bd. Describe			,,,,		
Divisi	ol or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Płace buildii	of Injury - Ang, etc. (Sp	At hom ecify)	ne, farm, stre	et, factory	, office		28	8f. Location (City or To	(Street and wn, State)	Number o	r Rural	Route Nur	n <i>ber</i> ,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C			sician: To the ner: On the ba and mann													s)
	To the within To the compl	Me	29b. Signature and title of cer	titer	1)			7			number				signed (M	onth, D	ay, Year)	
	\		Grada	0 /	1.	Sale	co		D	00	604	153		Hpri	1 15	> 0	200	5
	Ψ		30. Name and address of per		Calia	inic	an	23a) (Type, 1 00 FV	unk	lin	Dinv	e F	Balti.	nove	1,50	d =	712	37
	Sta Registr	100	31. Date filod (Month, Day, Yo	ear)	32. R	egigrar's Si	ignatu	J.	food	U								

_			1- For State of Maryland / Depar Registrar Certification	tment of Health and Me ificate of Death		2005 13124
	Physic /Medi Examir	cal	GEORGE WILLIAM BRAXTON		PRIL 15	2005 3. Time of Death 10:32A Ac. County of Death BALTIMORE
	Funeral Director			If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Yea 04/03/1	9. Birthplace (State or Foreign Country) 939 MARYLAND
	he Maryland 28a-f show otified at	ector	10a. State 10b. County 10c. City, Town or Loca MD BALTIMORE CATONSVI	LLE		10d. Inside City Limits 1 ☐ Yes ※XXNo
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-1 show mary injury or other treumatic event. Ite Medical Examble Lusal be notified at ance.	d by Funeral Director	3 ☐ Widowed XXDivorced Year or Dates:	21228 as Decedent of Hispanic Origin? (Specifes, specify Cuban, Mexican, Puerto Ri		USA 14. Race - American Indian, Black, White, etc. Specify: BLACK
2121	filed within 72 h Hygiene. other than "natu ent. It e Modical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2TH 1 YEAR 17. Father's Name (First, Middle, Last)	nt's Usual Occupation and of work done during most of working O NOT use retired) MAJOR E-9 18. Mother's Name (i	UI	Kind of Business/Industry VITED STATES ARMY
Maryland	12 should be h and Mental 7 Is marked o treumatic eve	To Be	WILLIAM BRAXTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	LOUISE Address (Street and Number or Rural F	JACKSON	1
Baltimore, I	Pages 1 and tment of Health tant: If item 27 jury or other to		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, cremation ARLINGTO	on (Name of tory or other place) N NATL CEM. 6/2	e 20c.	LTIMORE, MD 21210 Location - City or Town, State RLINGTON, VA
Bal	permit Depar Impor any in			0 LIBERTY HEIGH	HTS AVE	ERAL HOME 21207 BALTIMORE, MD Approximate Interval Batween
	/Medical Examiner	ilner	Immerit & Cause (Final disease or condition resulting in death) a. CHRON Due to (or as a consequence of):	DISEASE		Onset and Death S YEARS
68760,	ficate be executed physician and is the burial-transit	edical Examiner	resulting in death) Last C. Due to (or as a consequence of): d.			
O. Box	at the death certificate by the attending phys tached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec 4 □ Pregnant at time of death 5 □ Or 9 □ Unknown	stopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
ords, P.	The faw requires that the te has been signed by the age 2 should be detached.	by	ration. Other significant conditions contributing to death but not resulting in the under	orlying cause given in Part I.		use contribute to the cause of death?
Vital Records,		e Completed	25. Was case referred to medical	26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
Division of V	Hospitel or Attending Physicien: 24 hours after death 5 Funerel Director: After this certifica	ertification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	3 □ DOA Other: 4 □ Nursing Home		6 □Other (Specify) ury occurred
Š	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	0	4 Homicide determined 239. Place of injury - At nome, farm, street, building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge death or	occurred at the time, date and place, and	City or Town, Stat) and manner as stated
	To the He within 24 To the Fe completel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated. 29b. Signature and title of certifies.	29c. License number 29 3 2 / 86	29d. Da	ate signed (Month, Day, Year)
	14		30. Name and address of person who completed cause of death (Item 23a) (Type, Principle CONRAD MAY, M.D. 10 N. GREENE S	IT., BALTIMORE		
	Sta Registra	-	APR 1 9 2005 32. Registrar's Signature	we		

			1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygien	2000 13125
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) KAREN BRC 4a. Facility Name (If not institution, give street	OWN	4b. City, Town, or Location of Dea	2. Date of Death Apr. Da	ay 2005 1925 P M
	Examinum Funeral Director	ner	116 AKIN CIRCLE 5. Social Security Number 216-56-7505 1□ M	7. Age (In yrs. last birth	MIDDLE RIVER day) It Under 1 Year It Under 24 Hr Months Days Hours Mir	S. 8. Date of Birth (Month, Day, Year,	c. County of Death BALTIMORE 9. Birthplace (State or Foreign Country) 5.2 MARYLAND
	Maryland	tor	Usual Residence of Decedent	10c. City, Town of MIDDLE	or Location E RIVER		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow with injury or other treumetic event, the Medical Evantiner must be notified at once.	Funeral Director	37	Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 21220 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	USA	itizen of What Country?
21215-0036	72 hours after "naturel", or ite	by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educatic (Specify only highest grade co	1 Yes 2 No III Yes, Give Year or Dates:	1 ☐ Yes ♣☐ No Specify: ecedent's Usual Occupation Sive kind of work done during most of w	16h K	Specify: BLACK Kind of Business/Industry
	be filed within tal Hygiene. Set other then " event, the Mer.	Be Completed	12 2 17. Father's Name (First, Middle, Last)	College (1-40r 5+) MA	INTENANCE 18. Mother's Na	JHF me (First, Middle, Maider	
e, Maryland	and 2 should be ealth and Mental m 27 is marked o her treumetic eve	To	19a. Informant's Name/Relationship (Type, DANA BROWN / SON	16	Mailing Address (Street and Number or F	K WAY, BAI	24224
Baltimore,	mit. Pages 1 partment of H portent: If ite y injury or ott		20a. Method of Disposition XIDBurial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature p) Funeral Service Licensee	cemetery,	isposition (Name of crematory or other place) Y VALLEY MEM CAPPENS Ame and d ress of Facility H	6/05 BAL OWELL FUNE	CTIMORE CO, MD
	Anysivian		23a. Pant, Enter ne disease, or complication shock, or heart lailure. List only one call immediate Cause (Final disease)	ons that gaused the death. Do not ause or each line.	4600 LIBERTY H	GHTS. AVE,	BALTIMORE, MD Approximate Interval Between
THE REAL	/Medical Examiner	iner	disease or condition resulting in death) Sequentially list conditions, any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)		nar orseus	e loyears
8760,	cate be executed bhysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)			
O. Box 6	at the death certifica by the attending ph itached for use as th	Physician/Me	in the past 12 months?	f yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ords, P.	The law requires that the tte has been signed by th bage 2 should be detache	by	Part II. Other significant conditions contribu	uting to death but not resulting in th	e underlying cause given in Part I.		use contribute to the cause of death?
		Se Completed	25. Was case referred to medical		26. Place of De	24a. Was an autopsy performed? 1 Yes 2 No ath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?
o	Phys this ral di	ation; To B	eyaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ital: 1 Inpatient 2 ER/Outpa 9a. Date of Injury (Month, Day Year) 28b. Tim Inju	tient 3 DOA Other: 4 Nursing Fe ol 28c. Injury at		
DIVISION	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	al Certification;	4 Homicide	Be. Place of Injury - At home, larm, building, etc. (Specify)	street, lactory, office	City or Town, State	
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical	Check only 2 Medical Examiner:	On the basis of examination and/o and manner stated.	29c. License number	irred at the time, date and	d place, and due to the cause(s) te signed (Month, Day, Year)
	Ų	2	30. Name and address of person who comple	DEPUTY eled cause of death (Item 3a) (Type 1.0 MP Co True	D18667 mble 11:11 CT. La	Apr.	112,2005 Many land 21092
	Sta Registra	100	31. Date filed (Month, Day, Year) ADD 1 0 2005	32. a gistrar's Signature	Sparle	The state of the	,

State of Maryland / Department of Health and Mental Hygiefie For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CKET Physician 10 HARD APRIL Year 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATIMOR SUNACHTEAT NORTHWEST LANDALLITOWA If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □XM 2 □ F 227-12-4412 84 Director Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show wat be notified at 1 ☐Yes 2XNo Randallstown Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 **USA** 5401 Old Court Road 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items other traumatic event, the Madical Examiner. e filed within 72 hours after de il Hygiene. other than "natural", or Item Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If item 27 is marked other the eny injury or other traumatic event, ITEM 2006. 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Beckett, Sr. Maggie Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Wilson/Daughter 3218 Blazer Loop, Apt. 404, Woodbridge, VA 22193 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 4/14/05 Baltimore, MD 21. Sign vor of Funeral Service Ligensee 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Edward A. Gregorchik MD 21228 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): SOWEL-Examiner ONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown certificate has been si rector, page 2 should Completed 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Division of Vital 1 Yes 2 No the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 은 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4⊌Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAUI 31. Date filod (Month, Day, Year) Registrar

			1- For State of Maryland /		artment of H		Mental Hy	giene Reg. No.	2005	13127
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De	aath Day	Year	3. Time of Death
	/Media		Conrad Irving Berlie	ed			April	17,	2005	5:25 A ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		ith	4c.	County of Death	
			Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthdayl	Rockvil If Under 1 Year		S 9 Date of Bir		Montgome	
	Funeral Director		029-38-8854 1 M 2 F 56	Yrs.	Months Days	Hours Mir		y, Year) 194		place (State or Foreign ntry)
	ס		Usual Residence of Decedent				APR 12,	, 194	9 Mass	achusetts
	anylan show	_	10a. State 10b. County 10c. City, Tow	wn or Lo						10d. Inside City Limits
	Ba-f s	octo	Maryland Montgomery		Beth	esda				1 ☐ Yes 2 X No
	with t	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	eath	eral	6810 Wilson Lane 11. Marital Status 12. Was Decedent Ever in U.S.	12 1	20817		Specify Vec or No		SA 14. Race - Ameri	ago Indian
·0	r Itan	Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Was Decedent of H f Yes, specify Cuba	in, Mexican, Pue	nto Rican, etc.)		Black, White	
ဗ္ဗ	ours a	by	3 ☐ Widowed 4 🏋 Divorced If Yes, Give Year or Dates:	1	1□Yes 2X No	Specify:			Specify: Wh	nite
2	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show I.a M. cifal Exa. iliter: wat be neithed at	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	. Deced	tent's Usual Occupa	ation during most of we	orkina	16b. Kir	nd of Business/Ir	ndustry
7	vithin ne. han	пр	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired)				
2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	irpe	nter/Cabi		<u>r</u> me <i>(First, Middl</i> e		Contract	ing
Maryland 21215-0036	d be fead of	o Be	Irving Oswald Berlied				nces Gene			norri og
Z Z	should ind Men s marka umatic	ဥ		b. Mailin	ig Address (Street a					
	nd 2 lith a 27 is r tra				chool St		ton, MA			- ·
altimore,	of Hea of Hea itam rothe		20a. Method of Disposition 20b. Place of		sition (Name of natory or other place		Date		cation - City or T	own, State
Ĕ	Pages ment of I ant: If its ury or o	١,,	T Bullar 2 Molemation 3 Premoval non State		ematory,		19/05	Ва	ltimore	. MD
Balt	permit. Pages 1 Department of H Important: If ital any injury or ott		21. Signature of Fun, ral Service Licensee	C_r^{22}	Name and Address	s of Facility	of MD. T	nc.		
	00 = 4 O		Edward A Gregorchik 23a. Part 1. Enter the disease, or complications that caused the death. Do	29	9 Frederi	.ck Road	Baltimo	re,	MD 21228	
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Human Immuno Due to (or as a consequence)	Def	-			illest,		Approximate Interval Between Onset and Death Years
-/	pe tisi	lue	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury	of):						
S	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	of):				_		
8760,	cate be executed obly sician and the burial-transit	dical E	d							
0	tificat ng phy as th	ledi								
O. Box	The law requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			2	3d. Date of deliving Month	ery Day Year
Vital Records, P.	requires that the de een signed by the a tould be detached f	by	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.		obacco us		he cause of death?
Ö	s been 2 should	Completed					24a. Was		24b. Were auto	ppsy findings available
ž	The lav	mo					autor perfo	osy rmed? 2 \(\sqrt{No}	prior to co death? 1 ☐ Yes	mpletion of cause of 2[XNo
<u> </u>	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of De	ath (Check only o			Z
	Physicie this cert al direct	70	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient		4 14ul 3illy i	Home 5 Resid	dence 6	X Other (Specif	House
Division of	ding I h. After funer	Certification:	1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Time of Injury	28c. Injury Work M 1 🗆 Y	at ? ∕es 2 □ No	28d. Describe I	how injury	occurred	223 G.G.
Ž	spitel or Att ours after d naral Diract filled in by	Certif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (S City or Tox		Number or Rura	al Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) A Certifying Physician: To the best of my knowledge of the best of my knowledge on the basis of examination are and manner stated.	e, death nd/or inv	occurred at the tim restigation, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) and	and manner as s place, and due to	tated. o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier		29c. License			29d. Date	signed (Month,	Day, Year)
	Ţ.		Whi you			216114		Apr	il 18, 2	2005
	Ϋ́		30. Name and address of person who completed cause of death (Item 23a) Charles Harrison, M.D. Casey Ho		,	maach	Md 11 p	- J P	11 3	MD 00055
	Sta Registr	-	Charles Harrison, M.D. Casey Ho 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Juse	OUUI MU	uicaster	MITI KO	ad Ro	OCKV1116	e, MD 20855
			January Jan		144					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** William Henry Bell : 15 PM 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death **Examiner** HEALTHCARE BALTIMORE HENES | Style | State of Birth | State of Birt Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 85 192-18-2723 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

Is marked other then "neturel", or Items 23s or 28e-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f shoi other treumetic event, the Modical Examinational rust be confilled at 1 ☐ Yes 2 XNo Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane ST-610 21228 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 No 1943 If Yes, Give Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Henry Bell ျှ Florence Lockwood Rea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Stadium Avenue Mill Valley, CA 94941

Date 20c. Location - City or Town, State Pages 1 and 2 s ment of Health an item 27 Marcia R. Bell, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 04/14/05 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Lidence
Thomas Gregor Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL INFARCTION Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Conknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2□ No 1□ Yes _2X No 1 🗌 Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 ho To the Fune completely fi (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00 60 105 W APRIL

Registrar

31. Date filed (Month, Day, Year)

Istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAT ON AVENUE BALTIMORE

1. Decedent's Name (First, Middle, Last)

with Items 23a ö Baltimore, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours at of Health and Mental Hygiene. item 27 ie marked other then "naturel", of other treumetic event, the Madical Exert

BRETT

attending physician and

P.O. Box 68760, Division of Vital Records,

AMonth : SSAM Esther R. Brett 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Himo2 INAI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days Hours Min. 1 □ M 2 🗓 🕱 83 Yrs. 24,1921 u1yMaryland 215-16-0911 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County XXYes 2 □ No irier rust be notified at N/A Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1310 Medfield Avenue 21211 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 🏋 🖫 No Specify: β 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teamsters Local 557 Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Je, Maryla
Jermit. Pages 1 and 2 should be.
Department of Health and Merimportant: If item 27 in any injury or congress. Addie Long Jacob Brodsky 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Perry Hall, MD 21128 5002 Hilltop Acre Road Thomas A. Brett 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2005 Baltimore, Maryland Baltimore National 4 Donation 5 Other (Specify) 21. Signatur Jor Funeral Service License 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pach line. Approximate Interval Between Onset and Death neumonia Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit the Hoepitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed 2 No funeral director, 26. Place of Death (Check onl. one 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification; To 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral E Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D002426 pleted cause of death (Item 23a) (Type, Print) W. BeWedere Ave BA Himore, MD 21215 Name and address of person wi Ke,MO ERTZ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Year

2. Date of Death

3. Time of Death

		1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and Martificate of Death	lental Hygie	ne 2005	13130
Physic	ian -	1. Decedent's Name (First, Middle, Last				Day Year	3. Time of Death
/Medi Exami		EI.LIA O. BURN 4a. Facility Name (If not institution, give LONG VIEW NURS)	street and number)	4b. City, Town, or Location of Death MANCHESTER	APRIL 1:	3 2005 4c. County of Death CARROLL	7:35a [™]
Funeral Director		Social Security Number 6. Se			8. Date of Birth (Month, Day, Ye 05/01/1		place (State or Foreigntry)
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			0d. Inside City Limits
e Maryla la-f sho	Funeral Director	MD BALTIMO		RKS			1 ☐ Yes 2 📉 No
vith th	Dire	10e. Street and Number		10f. Zip Code		Citizen of What Cour	ntry?
eath v	eral	15827 YEOHO RD	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispania Origin? (Sp.		USA 14. Race - Americ	an Indian
be filed within 72 hours after death with the Maryland nat Hygiene. Indi Hygiene. Indicate than "natural", or Items 23a or 28a-f show event, the Modical Exercitive country to institled at	Þ	1 Never Married 2 Married 3 Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White,	
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should be Ind Mental I	2	WILLIAM ROBINS			LLA DARN		
를 5 를 달		19a. Informant's Name/Relationship (T) THOMAS BURKE (SO		ing Address (Street and Number or Rura 7 YEOHO RD SPAI			Code)
Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F		matory or other place)		Location - City or To	
permit. Pages Department of Important: If it any injury or o		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		MEMORIAL 04/25			Α.
Ø □ = € Ø		William / //	is in	ENRY W. JENKINS 6924 YORK RD MO		D. 21111	17.1
Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not en ne cause on each line. a	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
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The law raquirr rate has been si page 2 should I	Completed				24a. Was an autopsy performed 1 Yes 2	prior to cor death?	psy findings available appletion of cause of
Phyalclen: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	10 103	22110
Phyalc this ce al direc	10	1 Yes 2 No	fospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 Residence	6 □Other (Specify	/)
ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred	
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To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, avestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within 2 To the comple	¥	29b. Signature and title at certifier		29c. License number 33 \ 6 5	29d.	Date signed (Month,	Day, Year)
Q		30. Name and address of prison who co	ompleted cause of death (Item 23a) (Type		dant	ita) a	2 21074
St	ate	31 Date filed (Month Plans Vear)	32. Engistrar's Signatur	book	1		

State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 50 AP LIL **Physician** B4516 GLENNA 16 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Hospital Baltimore ff Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 24, 1 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 M 2 X F 82 Yrs. Maryland 216-12-3226 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar relatible as 1X Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3002 Fleetwood Avenue 21214 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🎾 No Specify: White Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the We Elementary/Secondary (0-12) College (1-4or 5+) Teacher Baltimore City 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Edward Lola Marie Routzahn Harner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21214 Mrs. Linda M. Lingner /Daughter 5901 Theodore Avenue Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pages 1 permit. Page Department of Important: If any injury or Moreland Mem. Park 04/21/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCON MUTHSTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 3 ☐ Probably 4 ☐ Unknown 2 X No 1 Tyes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 ER/Outpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death After 5 Pending investigation 1 Naturaf 1 □ Yes 2 □ No М death. 2 Accident the Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after ō within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AMR. 16, 2005 DI5135 21235 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUID ATVEN BLUD BARN MINK, SWIT NENEWAL 5601 31. Date filed (Month, Day, Year) 32. Reg State

Registrar

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			Decedent's Name (First, Middle)	a, Last)			11110011	0, 1			2. Date of De	eath		3. Time of Death
	Physici		Anna Eugenia	Belendiuk							April	13	2005	7:44 P M
	/Medic Examin		4a. Facility Name (If not institution		er)		4b. City,	Town, or	Location of	of Death		4c. Count		,, ,,, 1
			Suburban Hosp	ital			Bet	thes	da				Mont	gomery
	. Funeral		5. Social Security Number	6. Sex 7.		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth av, Year)		lace (State or Foreign
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	72 hours after death with the Maryland 'natural', or Itams 23a or 28a-1 show Alsa Examinet must be notified at	Funeral Directo	11. Marital Status	12. Was Decede	ent Ever in U	l.S. 13.			ispanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)		ce - Americ	an Indian,
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Maryland 21215-0036	d be intal l	Be	Arthur V. Bele								Soltys	, wardon cama	1107	
7	should nd Me mark matic	은	19a. Informant's Name/Relations			19b. Mailir	na Address	(Street a				er, City or Town	State Zin	(Code)
Z S	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Modical Examiliate in ust be notified at Once.		Arthur V. Bele		er		_					Marylar	- 0.0	0817
Baltimore,	s 1 au f Hea itam otha		20a. Method of Disposition		20b F	Place of Dispo	sition (Nam	ne of	T		Date	20c. Location		own, State
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687	eath certificate be executed attending physicien and for use as the burial-transit	adic		d										
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	ding F	lon	27. Manner of Death 1 □ Natural 5 □ Pendin	9 111 - 10	Day Year)	28b. Time of	^	Bc. Injury Worl	ς?		010 1	how injury occur	rred	0
Sic	Attanding r death. ector: After by the fune	icat	2 Accident investig	not be	S Indiana At h	6:50			Yes 2 🔼	No	subject	Street and Num	nersel.	/ Pouts Number
Division	in Steel	Certification;	4 ☐ Homicide determ	building	, etc. (Specif	ome, farm, str fy)	eet, ractory	, onice			City or To	wn, State)	D-II	A M
-	To the Hospitel within 24 hours a To the Funeral completely filled	C	29a. Certifier 1 Certifyin	g Physician: To the b		owiedge, deat	a occurred a	at the tim	e date an			-	anner as si	tated (VII)
	a Hos 24 h a Fur letely	edical	(Check only 2X Medical one)	Examiner: On the bas and manne	is of examina	ation and/or in	vestigation,	in my or	oinion, dea	th occur	red at the time.	date and place,	and due to	the cause(s)
	To th within To th	Me	29b. Signature and title of certifie	r			29c	License	number			29d. Date signe	ed (Month,	Day, Year)
	4		I him a	i, miD				OC	CME			April	14. 2	005
1	200		30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type,						2013		
1	5		LING L	I, M.D				11 I	Penn S	Stre	et Bal	timore,	Mary	land 21201
10	Sta		31. Date filed (Month, Day, Year)	200E 3 Reg	istrar's Signa	ture for	de							
	Registi	ar	WAK T A	2005	مكر معاد	14	0.74							

		-	For State Registrar	State of Maryl			tment of H <i>ificate of L</i>		/lental Hy	giene Reg. No.	- 11 11 1	13133
			Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
	Physicia		FREDERICK		BENTL	EY .	IR		APR	Day 15	2005	11:36 P _M
	/Medic Examin		4a. Facility Name (If not institution, give		<u> </u>			Location of Death		4c.	County of Deat	
	LAGITIII	ÇI	NATIONAL NAVAL M	EDICAL CENT	ER		BETI	HESDA			MONTGOM	ŒRY
	Funeral		5. Social Security Number 6. Sec	7. Age (In)	yrs. last birti	hday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9. Birt	hplace (State or Foreign
	Director		096-16-0053	M 2□F	83	Yrs.	Months Days	Hours Min.	March	29,1	922 New	York
	ס		Usual Residence of Decedent									
	how Let		10a. State 10b. County	10c.	. City, Town	or Loca	ation					10d. Inside City Limits
	e-fs	cto	Maryland Montgomer	у	Rock	vil1	Le					1X Yes 2 □ No
	or 28	lre	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Co	ountry?
	23a (Funeral Director	13301 Okinawa Aver	nue			20851				ed Stat	es
	dea	ner	11. Marital Status	12. Was Decedent Ever i		13. W	as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
9	within 72 hours after death with the Maryland ene. then *natural', or Itama 23a or 28e-f show tw Medical Evardinar must be notified at		1 ☐ Never Married 2 Married	1 XIYes 2 ☐ No W	WII	1	☐Yes 2⊠ No	Specify:			Specify: Wh	
21215-0036	ral',	d by	3 Widowed 4 Divorced	If Yes, Give & K Year or Dates:	orea				<u> </u>			
5-0	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad		16a.	(Give ki	nt's Usual Occupa ind of work done of	ation <i>furing</i> most of worl)	king		ind of Business/	Industry
2	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	7.					Fede		
2	ed w ygier ygier yertl	S		1	Me	char	nical Eng	gineer 18. Mother's Nam	on (First Middle		rernment	
D L	be fil tal H d oth	Be	17. Father's Name (First, Middle, Last)					Gladys E				
<u>X</u>	Men	7	Frederick Bentley		101	4.4 20.7	111					Tin Code)
Maryland	2 sh and ts rr		19a. Informant's Name/Relationship (T)	_		_		Avenue,				
e di	and fealth m 27 her t		Mary Georgianna Be						Date		ocation - City or	
altimore,	ges 1 t of F ff Ita or ot		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ F	Removal from State	cemeter MO	y, crema	ition (Name of atory or other plac Omery	(a) April	L 19,			
E	Pag menitant:		*4 □ Donation 5 □ Other (Specify)	~ C		ori	ım, İnc.	200)5	Beth	nesda M	laryland ineral Home/
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or Itama 23a or 28e-1 show any injury or other traumatic event, Ira Medical Examinat must be notified at ance.		21. Signature of Funeral Service Lions	1	1689	Roc	ckville,	Inc. 300) West I	Montg	gomery A	venue,
	_		23a. Part 1. Enter the disease, or compleshock or heart fadure. List only o	lications that caused the	death. Dor	not enter	r the mode of dyin	g, such as cardiac	or respiratory	arrest,	7-2005	Approximate Interval Between
			Immediate Cause (Final									Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a HEMORRHAO Due to (or as a cor	_	of\.						
	Examiner						I IOTT ON					
l,	- 00	ē	Sequentially list conditions, if any, leading to immediate	b. SMALL HOL Due to (or as a cor	nsequence	of):	UCITON					
	petr	듵	cause. Enter Underlying Cause (Disease or injury that initiated events								1	
	execunation and	Examiner	resulting in death) Last	Due to (or as a cor	nsequence	of):						
8760,	icate be executed physician and s the buriat-transit	a	(d.								
687		edical		**								
Box	death certifi e attending I od for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		۰.					23d. Date of de	*
	death atte	cla	in the past 12 months?	1□Live birth 2□ 4□Pregnant at time			Ectopic pregnancy Other (specify)				Month	Day Year
0	that the de led by the a detached f	lys	9 Unknown	9□ Unknown								
σ.	requires that the been signed by th hould be detache	by Pi	Part II. Other significant conditions co	ntributing to death but no	t resulting in	n the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ds	puires in signe								1 🗀	Yes 2	X No 3 □ Pi	robably 4 Dunknown
Record		Completed							24a. Wa		24b. Were at	utopsy findings available
Re	The law ate has b page 2 si	E G							per	opsy formed?	death?	completion of cause of
a	icien: Th certificate rector, pag	e Co	25. Was case referred to medical					26. Place of Dea		2 No	1 1 1 1 1 1 1 1 1 1 1 1	2 100
Vital		m	examiner?	Hospital:	2 □ EB/O	tnation	3 DOA Oth	or			6 ☐Other (Spe	icifu)
of		: To	1 ☐ Yes 2 ₹ No 27. Manner of Death	28a. Date of Injury	28b.	Time of	28c. Injur	y at	28d. Describe			ony
on	ding I h. After tuner	tlor	1 X Yaxral 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) I	Injury	Wor M 1 □	k? Yes 2 ∐ No				
Si	Attending ir death. ector: Afte by the fune	lica	3 Suicide 6 Could not be	28e. Place of Injury -	At home, fa	arm, stre	et, factory, office					ural Route Number,
Division	F H F C	Certification:	4 Homicide	building, etc. (S	pecify)				City or 1	own, State	θ)	
	ospite hours unerel ly filled		29a. Certifier 1XX ertifying Phy (Check only 2 ☐ Medical Exem	vsician: To the best of my iner: On the basis of exa	y knowledge	e, death	occurred at the tir	me, date and place	and due to th	e cause(s) and manner as	s stated.
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical	29b. Signature and title of certifier	and manner stated.			29c. Licens				ite signed (Mont	
	T W O			_				2371A (IN	1)		4 44	2005
7			· W.(U				1	TIONAL N		אים דרוי אים דרוי		
11	117		30. Name and address of person who o	completed cause of death	(Item 23a)	(1ype, F		TTONAL N THESDA M				
1			W.M.POLEN LT 31. Date filed (Month, Day, Year)	MC USNR 32. Sgistrar's	Signature			TITIODE L	2000	300		
	St Regist	ate rar	APR 192		, K	19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Apri 2005 Janice L. CLARK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMURC SINAI HOSPITA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F Months Hours Yrs. **Director** South Carolina 248-86-3061 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. Count 10d. Inside City Limits 10a State 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinations to confilled at 1 ☐ Yes 2 X No Directo Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21208 USA 4218 Lowell Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African-1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: ğ 3 ☐ Widowed 4 ☑ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore, Maryland 2121 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Apex Draperies 12 Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be f Kate Butler Harry Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important; If item 27 is any injury or other trauonce. 612 Greenwood Road Pikesville, Maryland 21208 Katie Walker/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park April 20, 2005 Arbutus, Maryland 22. Name and Address of Facility Wylie Funeral Home PAof BC 21. Signature of Funeral Service Licenses 9200 Liberty Road Randallstown, Maryland 21133 shock, or heart failure. List only Approximate Interval Between Onset and Death he that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner WAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 ₽No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examilar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann eath 28a. Date of Injury (Month, Day Year) e Hospital or Attending PP , 24 hours after death. e Funeral Director: After,tl 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours all To the Funeral D 29a. Certifier 1🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ()n 2005 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 2401 West Belvedere Avenue Tarig Khan Baltimore, Md 21215 31. Date filed (Month) Day, Year) 2005

DHMH 17 Rev 1/2001

Registrar

JARK, SAR

32. Registrar's Signature

		1 - For State Registrar	State o	of Marylan		artment of H			_	giene	05	13135
, Physi	cian	Decedent's Name (First, Middle	e, Last)						2. Date of De Month		Year	3. Time of Death
/Med	dical	Mack Coleman 4a. Facility Name (If not institution	n give street and nu	imber)		4b. City, Town, or	Location o	of Death	April 1	-	inty of Death	2:30 A M
Exam	niner	1027 Cathedral St.		intoer)		Balti		JI DOGUI			VA	'
Funera	al	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bird (Month, Da		9. Birth	place (State or Foreign intry)
Directo	or	217-30-4502 Usual Residence of Decedent	1 X M 2□F	67	Yrs.				12-02-1	937	Mary	
/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Many a-fah	tor	MD NA	1		Balt	imore						1∭Yes 2☐No
ith the	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	untry?
eath w	erai		Apt 3B	edent Ever in U	e 13 1	21201		ain? /Sne	ocify Vac or No	US	SA Race - Amer	ican Indian
fiter d	Fun	11. Marital Status 1 X Never Married 2 ☐ Mar	ried Armed F	orces? 2 📉 No		Was Decedent of Hi f Yes, specify Cuba			Rican, etc.)	-	Black, White	
of ZIZIS-UUSO filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ahow snt, the Medical Eral: a writingthe Lodific at	d by	3 Widowed 4 Divorced	If Yes, G Year or I	ve Dates:		1 ☐ Yes 2 🛣 No	Specify:			Spe	Blac	ck
natu	Completed	15. Deceder (Specify only highe	it's Education st grade completed)	(Give	tent's Usual Occupa kind of work done of DO NOT use retired	turina mos	t of worki	ng	16b. Kind o	f Business/I	ndustry
d with d with giene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ntainance	,			.Tobr	is Hopk	ins Hospital
ITYIZITG Z IZIJ-UUJO should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or flems 23a or 28a-f ahow imatic event, the Medical Erar, in primatice profilical.	Be C	17. Father's Name (First, Middle,	Last)			TOO LIMITOO	18. Mothe	er's Name	(First, Middle,			ins inspical
should be nd Mental marked c	10	Mc Cuthen Coleman						ah Col				
Wild I		19a. Informant's Name/Relations Lela M. Hairston/			1	ng Address (Street a Shburton St					wn, State, Zi	ip Code)
s 1 an f Heal item 2 other		20a. Method of Disposition			lace of Dispo	sition (Name of matory or other place	Ţ)ate		on - City or T	own, State
Pages nent of int: If it		1 🖾 Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5		State	-	orial Park		¥-21 -	05	Baltimor	e. MD	
baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic.	once.	21. Signature of Funeral Service	Licensee			. Name and Addres		95333333		mragae garo	-VS-00	CHINAMANANA I
n 907 e	OI	23a. Part1. Enter the disease, o	yours.	Daysad the deat		lylie Funera					alto, M	D 21217 Approximate
Dharis		shock, or heart failure. List	only one cause on	each line.			g, 30011 us	our draw o	i respiratory a	1031,		Interval Between Onset and Death
Physicia /Medica	al	disease or condition resulting in death)		(or as a conseq		1 (-61						Imonth
Examine		Sequentially list conditions.	b	74	Cer							
ed list	ujuei	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to	(ir) is a conseq	uence of):							
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
ate be executed only sician and the burial-transit	icai		d									
as as	/Med	IF FEMALE:	220 If yes of	atcome of pregna	2007							
BOX eath cer attendir for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta nant at time of d	Ideath 3	Ectopic pregnancy Other (specify)				l l	Date of deliving Month	Day Year
the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	nown								
uires that the densigned by the a	b V	Part II. Other significant conditi		death but not res	ulting in the u	nderlying cause give	en in Part I.			_		the cause of death?
cords, wrequires to been signed should be	eted	None Know	<u></u>							Yes 2□No	,	
The law rate has be page 2 s	ompleted									rmed?	prior to co death?	opsy findings available ompletion of cause of
VICAL NEC vician: The lav certificate has rector, page 2	O	25. Was case referred to medica	ıl				26. Place	of Death	1 Yes	-	1 🗆 Yes	2 X No
d is	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 □	Inpatient 2	ER/Outpatier	nt 3□ DOA Othe	er: 4 🗆 Nu	rsing Hor	me 5 Resi	dence 6 🗆	Other (Spec	ify)
on on ding Ph h. After th funeral	ion:	27. Manner of Death 1 Natural 5 □ Pendi	'9	of Injury oth, Day Year)	28b. Time of Injury	Work			28d. Describe I	now injury oc	curred	
VISION r Attending er death. rector: Afte by the fune	ertification;	2 Accident invest 3 Suicide 6 Could determ	not be 28e. Plac	e of Injury - At h	ome, farm, str	eet, factory, office	Yes 2□	-			ımber or Rui	ral Route Number,
DIN safter al Dire	Certi	4 Homicide	build	ling, etc. (Specia	(y)				City or Tox	vn, State)		
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical ((Check only 2 Medical	ng Physician: To th Examiner: On the	e best of my kno basis of examina	owledge, deat	n occurred at the time vestigation, in my or	ne, date an pinion, dea	id place, a	and due to the	cause(s) and date and place	manner as	stated. to the cause(s)
thin 2 the l	Med	one) 29b. Signature and title a certifie		ner stated.		29c. License	a number			29d. Date sig	ned (Month	, Day, Year)
F 3 F 8	-	1/60	ssistant fro	faces of	Oncolor	000		01	4	April		-
4		30. Name and address of person	who completed cau	ise of death (Iter	n 23a) (Type,	Mint)	-72				, , ,	
J		Ben Park MOPLO		Orleans Bogistrate Signi	51.	Baltimore	r, M	U	2/23/			
Regi:	State strar	31. Date filed (Month, Day, Year APR 19	2005	Registrar's Sign	ature	Carlo Carlo						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 10d per fh 8842 4-28-05 vt. State of Maryland, Repairment of Health and Mental Hygiene Item#19b, Per FH, 6842, 4/22, 4/26 of Death For Amend Item/19b, Per Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** APRIL 15 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMORE UTURE CAME NH RANDAUS TOWN OLDCOURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 0 F 220-20-8659 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-1 show iner sust be notified at Pig Yes 2X No Directo Nacyland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 36 2 Itams 23s uood Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🜠 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: δ other traumatic event, If a Medical Exar Black 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Investigating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F should be Magg 10 ames HI 19a. Informant's Name/Relationship (Type, Print) (Husband) Route Number, City or Town, State, Zip Code 21207 19b. Mailing Address (Street and Number of Him of Health of item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) altimore, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/25 12005 ö 1 Department c Important: If any injury of once. Garrison tore 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Home P.A. L. R. Funeral Ha W. North Ave. 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fetilure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any seeing to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Exami Box 68760 冬 Due to (or as a consequence of): physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? certificate 2 No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No 2 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Anatural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 24 hours after death a Funeral Diractor: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the tha within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number APRIL IJ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21133 MO J400 010 (TRD) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2005 Registrar

 C_{OUNCi} , Hele M

			Please	Type or Print in E	Black Indelible In	k. Ensure All (Copies Are	Legible.
			1_ For State	State of Marylan	d / Department of		ntal Hygiene	005 13137
		_	Registrar 1. Decedent's Name (First, Middle, Lat	et)	Certificate of		Reg. No.	3. Time of Death
П	Physici		Holon C	ouncil		A	Month Day	2005 9740p M
	/Medic Examin		4a. Facility Name (If not institution, give	- A	4b. City, Town	, or Location of Death	4c.	County of Death
			SINAI	HOSPI(A)	last birthday) If Under 1 Yea	timore		9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. S 214-22-0480 1 Usual Residence of Decedent	ex 7. Age (In yrs.	Yrs. Months Day		Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign 27 Maryland
	filed within 72 hours atter death with the Maryland Hyglene. ther then "netural", or Items 23a or 28e-f show ther then "netural", or Items 12a to to title Jat	ctor	Maryland 10b. County	A 10c. Cit	y, Town or Location Baltimor	e		10d. Inside City Limits 1 XYes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importents if item 27 is marked other then "neturat", or Items 23a or 28e-1 show any injury or other treumatic event; the Medical Eval is act must be calified at DDCs.	ral Directo	2503 Viole	t Aue. #50	75 21	215		zen of What Country? USA
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No	S. 13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Specif uban, Mexican, Puerto Ric	y Yes or No- can, etc.)	 Race - American Indian, Black, White, etc.
5-0036	ours a	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 💢 N	lo Specify:		Specify: Black
15-0	"netu	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	ne during most of working	16b. Kii	nd of Business/Industry
2121	d withii giene. rr then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Dieticia		Pro	vident Hospita
	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)	0		18. Mother's Name (/	irst, Middle, Maiden	Sumame)
Maryland	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, I'≖ I's	Ç	Philmore 19a. Informant's Name/Relationship (Saunder	19b. Mailing Address (Stre	Anna	Lass	SITER
	1 and 2 s Health an em 27 is i		Mrs. Maanolia	Powell	2503 Viol	et Ave #	5075	Balto, M1, 21215
Baltimore,	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		lace of Disposition (Name of emetery, crematory or other p	Date Date	20c. Lo	cation - City or Town, State
tim	permit. Pag Department Importent: I any injury o		'4 Donation 5 Dother (Specific	(v)	VIt. Lion	7/23/2	1005 La	nsdowne, Ma
Bal	permit. Departr Importe any injl		21. Signature of Funeral Service Micer	LIAN.	Joseph L	RUSS F	uneral 1	Home P.A.
			23a. Part 1 Enter the dispase, or com shdct, or heart failure. List only	plications that caused the death	h. Do not enter the mode of d	lying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	sepsis	S			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):			
	led sit	kaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	b. Due to (or as a consequence)	uence of):			
, o	executed an and rial-transit	Exal	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):			
68760,	ate be hysicia the bu	licai		d				
9 X	certific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	incv			23d. Date of delivery
. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq\text{Yes}\) 2 \(\subseteq\text{No}\)	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	I death 3 □Ectopic pregnar			Month Day Year
P.0.	at the d by th etache	Phys	9 🗆 Unknown	9□ Unknown			One Did teheses w	as contribute to the source of death?
	signer d be d		Part II. Other significant conditions of	5 TRuctive	outing in the underlying cause of	^-	1 Yes 2	se contribute to the cause of death? No 3 Probably 4 Unknown
cor	w requires been si	lete			1	1	24a. Was an	24b. Were autopsy findings available prior to completion of cause of
l Re	The la ate has page 2	Completed by					autopsy performed?	prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \)
Division of Vital Records,	Physicien: this certificated director, i	Be	25. Was case referred to medical examiner?	Hospital:	,	26. Place of Death (C		
of	Physic r this c	. To	1 ☐ Yes 2 No 27. Manper of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. In		5 Residence 6 Describe how injury	
ion	ath. r: Afte	atior	1 Natural 5 Pending 2 Accident investigation			Vork? ☐ Yes 2 ☐ No		
ivis	or Atte	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factory, officially)	286	Location (Street and City or Town, State)	d Number or Rural Route Number,)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Pt	ysician: To the best of my kno	wledge, death occurred at the	time, date and place, and	d due to the cause(s)	and manner as stated.
	n 24 h n 24 h he Fur pletely	Medical	(Check only 2 Medical Example)	niner: On the basis of examina and manner stated.	tion and/or investigation, in my	y opinion, death occurred	at the time, date and	place, and due to the cause(s)
	Withi To t	Σ	29b. Signature and title of certifie	01 '		ense number	29d. Date	e signed (Month, Day, Year)
•	1.		20 Name ded address of access to	thy SICIA	233) (Type Brint)	554558	MAL	11 11 5002
	1/		30. Name and address of person the	BURKE TRIM!	2401 W.Be	lvedere A	ve BAI	timore, mozIZIS
	Sta		31. Date filed (Month, Day, Year) APR 1 9 20	37 Registrar's Signa	iture /			
	Registi	ar	APK T 3 20	103 JULIOUS DO				

Registrar DHMH 17 Rev 1/2001

		-	For State Registrar	State of Maryland		epartment of Health Certificate of Deat			giene Reg. No.	005	13138
	Physicia		1. Decedent's Name (First, Middle, Last)	ARD CV	51	C		2. Date of Dea	ath Day	7 Kyear	3. Time of Death
	/Medic Examin Funeral Director	er	5. Social Security Number 6. Sex 212–26–5990			4b. (Iv. Town) o Locatio holay) If Under 1 Year If Und Months Days Hours	der 24 Hrs.	2122 B. Date of Birth (Month, Day AN. 5,	7 V. Year)		ath A
	aryland show	10	Usual Residence of Decedent 10a. State 10b. County MD Baltimore			or Location					10d. fnside City Limits 1 ☐ Yes 2 No
	h with the M 3a or 28e-f	Funeral Director	10e. Street and Number 1244 Maple Avenue			10f. Zip Code 21227			-	zen of What C	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event, if a Madical Examinant be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☒ No Specify		ify Yes or No- ican, etc.)		4. Race - Am Black, Wh Specify: Wh	ite, etc.
21215-003	within 72 hou ane. than "neture	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+)		Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) School Bus Drive		7		ablic S	Schools
nd 2	al Hygid d other ovent, I	Be Co	17. Father's Name (First, Middle, Last)			18. Mo	other's Name		Maiden .		CHOOIS
aryland	should be tind Mental is marked o	2	Paul J. Cusic	The state of the s	101		ra But			T C4-4-	7/- 0-4-1
Mar	d 2 sh th and 7 is π treum		19a. Informant's Name/Relationship (Ty). Susan Ring - da	ughter		Mailing Address (Street and Num 27 Heron Drive,			2122		Zip Code)
re,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. Pfa		Disposition (Name of v, crematory or other place)	Da			cation - City o	r Town, State
<u>m</u>	Pages nent of I ant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emovariiom State		eake Crem., Inc	4/19	/2005	Bel	ltsvill	e, MD
Baltimore,	permit. Page Department Importent: II any injury o		21. Signature of Funeral Service License			22. Name and Address of Fac Gary L. Kaufma 7250 Washingto	<u>n Blvd</u>	., Elkı	ridge	Meadown	ridge MP, Inc. 21075
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ie cause on eagh line.					rest,		Approximate Interval Between Onget and Death
	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	-	Caver	nen	Ma	_		1/2 year
	Examiner		0	D00 to (01 as a conseque		3 .					
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce c	of):					
V	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce c	of):					
8760,	cate be executed physician and the burial-transit	dlcal E		I							
Θ	E D e	(a) t	IF FEMALE:								
.O. Box	that the death certificated by the attending postering the detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	leath	3 Ectopic pregnancy 5 Other (specify)			2	3d. Date of de Month	olivery Day Year
s, D	es be	by	Part ff. Other significant conditions con	ntributing to death but not result	ing in	the underlying cause given in Pa	art I,	\ \			ro the cause of death?
Sor	v requir been si should	eted	-au	Vy Serv	-			24a. Was	_		utopsy findings available
al Record	The ate h page	Completed		J				autop perfor	sy	prior to death? 1 □ Ye	completion of cause of
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:	B (0.	Other	ace of Death		he)		
of	Phys er this eral di	n: To	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ Y	28a. Date of Injury	28b. T	ime of 28c. fnjury at	Nursing Hom	e 51 Resid		Other (Sp.	ecity)
ion	Attending r death.	atlo	1 Natural 5 Pending investigation	(Month, Day Year)	ır	M 1 ☐ Yes 2	! □No				
Division	el or Atte s after de d Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of fnjury - At hon building, etc. (Specify)	ne, far	rm, street, factory, office	28	Bf. Location (S City or Tow			Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director.	edical				, death occurred at the time, date d/or investigation, in my opinion, c					
)	To ti withi, To ti	M	29b. Signature and title of certifier	aralia	^	29c. License number	19)	8	29d. Date	signed (Mor	0 14
	12+1		30. Name and address of phrson who	empleted cause of death (Item)	(Mario .	Jan	0	Sal	time	18/42005 re M21229
	Sta Regist		31. Date filed (Month, Day, Year)	9 2005	ire	J. Sparle					
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			For State Registrar	State of	f Maryland	d / Depa <i>Cei</i>	artment of H	ealth and Death	d Mental Hy	giene (2005	13139
	ų, p		1. Decedent's Name (First, Middle,	Last)					2. Date of De. Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic	al	Joseph M. Ciri						April	16,	2005	12:01A M
	Examin	er 🖹	4a. Fecility Name (If not institution,		nber)		4b. City, Town, or	Location of De altimor		4c. C	ounty of Death N/A	
			2607 Brendan A 5. Social Security Number		7. Age (In yrs. la	ast hirthday)	If Under 1 Year	If Under 24 F		th		
<i>(*)</i>	Funeral Director		219-10-5298	1 M 2 □ F	84	Yrs.	Months Days		Hrs. 8. Date of Bir (Month, Da March 2	y, Year)	21 Cou	place (State or Foreign ntry) Aryland
3		1	Usual Residence of Decedent						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 1 Yos 2 □ No
	e Ma	cto	Maryland N/	A				imore				
	or 28	Director	10e. Street and Number				10f. Zip Code	01012			en of What Cou	
	s 23s	rai	2607 Brendan Av		edent Ever in U.	S 13 1		21213	(Specify Yes or No		J. S. A	
	iled within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show out, it is Marical Examiner must be notified a	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie	Armed Fo	rces? 2X1No				(Specify Yes or No Jerto Rican, etc.)		Black, White	etc.
99	urs al	by	3 Widowed 4 Divorced	tf Yes, Giv Year or Da	e ates:		1□Yes 2Å No	Specify:		S	Specify:	White
Ö 2	72 ho	Completed	15. Decedent' (Specify only highest	Education grade completed)		/Giva	dent's Usual Occup	du <i>rina</i> most of i	working	16b. Kind	of Business/Ir	ndustry
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired	7)		C la	ip Buil	dina
2	lled w tygie ther ti	S	8th Grade 17. Father's Name (First, Middle, L	ast)			Marine Ma		L Name (First, Middle			urng
anc	od of	Be	Dominic Ciri						ny Baranc			
Maryland 21215-0036	should mark mark	ို	19a. Informant's Name/Relationsh			19b. Maitii	ng Address (Street		Rural Route Numb		Town, State, Zi	o Code)
	nd 2:		Michael Cirinc	ione (Son)	260	7 Brendan	n Avenu	e, Baltim	ore,	Marylan	d 21213
Jre,	of Hei		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Demoual from	1 ~	lace of Dispo emetery, crea	sition (Name of matory or other place	ce)	Date	20c. Loca	ation - City or T	own, State
Ĕ	Page nent: M ury or		° 4 □ Donation 5 □ Other (Sp		Ga		of Faith		20/2005			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, Ite Maryleal Examiner must be notified at ODGs.		21. Signature of Funeral Service L	icensee	/				Schimunek , Baltimo			
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List of the timediate Cause (Finat disease or condition	inly one cause on e	aused the death each line.		•	ig, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
卖	/Medical		resulting in death)	Due to	(or as a consequ	uence of):	•					1
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1	led Isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(Or as a consequ	uence 01).						
10	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to	(or as a consequ	uence of):						
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89	tificat ng phy as th	ed	IE EENALE.									
O. Box	it the death certifica by the attending phached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	tcome of pregna pirth 2 Feta nant at time of di own	Ideath 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	<u> </u>		23	3d. Date of deliving Month	very Day Year
<u>α</u>	that the		Part II. Other significant condition				inderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
sp.	juires thai n signed l	d by	MRIAL	FIBRI	lladio.	n			1	Yes 2	No 3□Pro	bably 4 Unknown
Vital Records,	The law requires that tte has been signed b page 2 should be deta	Completed							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Re	The lav	mo								med? 2≥No	death? 1 ☐ Yes	20 No
ital		BeC	25. Was case referred to medicat examiner?						Death (Check only	опе)		
of V	ys dilb	To	1 Yes 20 No			ER/Outpatie		4 1401511			Other (Spec	ify)
n o		on:	27. Manner of Death		of Injury oth, Day Year)	28b. Time o Injury	Wo	yat rk? Yes 2 ∐ No	28d. Desdribe	how intury	occurred	
Sio	tend feath tor: the	icati	2 Accident investig	ot be 380 Place	a of Injuny . At he	ome farm et	reet, factory, office	165 2 140	28f. Location	Street and	Number or Ru	ral Route Number,
Division	if or Attendated after death Director:	Certification:	4 Homicide determi	ned build	ing, etc. (Specif	y) , ann, so	root, ractory, onloo			wn, State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only 2 Medical one)	xaminer: On the b	e best of my kno pasis of examina iner stated.	wledge, dea ition and/or in	th occurred at the ti	me, date and p opinion, death o	lace, and due to the	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifie	Barla	en V	w	29c. Licen:		08		signed (Month	
	6		30. Name and address of person	who completed cau	se of death (Item	n 23a) (Type	Print) 3243	6.1	108 1100	SV	-	
		ate	31. Date filed (Month, Day, Year)	£2 .	Registrar's Signa	ature Ange	7	٠.	, -, 4			
	Regist	rar	APR 192	005	Mes St.	A. T. T. S.						

			for State	State of Ma			Health and Me	ental Hygie	4000	5 1311.1
	Dharaini		Registrar 1. Decedent's Name (First, Middle,	Last)	(T 1 -	runcate of		Reg. 2. Date of Death Month	No. Day Year	3. Time of Death
	Physici /Medic	al	4a. Eacility Name (If not institution,	aive street and number)	CAR	4b. City. Town.	or Location of Death	APRIL 1	3 2005 4c. County of Deatl	1105 AM
	Examin	er	JOHNS HOPKINS	BAYVIEW		a B	ALTIMOR			
п	Funeral Director		5. Social Security Number 218 - 44 - 5305	5. Sex 7. Age 1 ☐ M 2 💢 F	e (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye	9. Birtl Co	nplace (State or Foreign untry)
	yland 10w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation		•		10d. Inside City Limits
	the Mar 28a-f sl	ector	BA:	LTIMORE	TURNER S	TATION		10-	Citizen of Minas Co	1∑Yes 2□No
	3a or	i Dir	208 CENTER S'	FREET		21222		Tog.	Citizen of What Co USA	untry?
	death	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13		Hispanic Origin? (Spec an, Mexican, Puerto Ri	ify Yes or No-	14. Race - Ame	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-f show may injury or other traumatic event, the Medical Eventinal maint be nutified at ances.	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced		10	1 ☐ Yes 2 🎇 No		oan, etc.,	Specify: B	LACK
215-0036	"natura	Completed	15. Decedent's (Specify only highest		(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of working	16b	. Kind of Business/I	ndustry
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Ž	should Ind Meni	Ţ	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mai	ling Address (Street	ANNIE C		ity or Town, State, Z	ip Code)
	and 2 salth ar n 27 is		LETTIE C. BRATCI	IER/DAUGHTEF		-	E AVE., BA			
Baltimore,	Pages 1 and of He int: if itan		20a. Method of Disposition † Burial 2 Cremation			ematory or other pla			. Location - City or	
altin	permit. Pa Departme Important any injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		MEADOWRI		4/20/0 ess of Facility JAME		KRIDGE, M TON & SON	S F.H., INC
ä	permi Depar Impo any ir		James	a. Mort			ENS STREET			
	Pnysician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lin	the death. Do not ended		ng, such as cardiac or	respiratory arrest,	Se	Approximate Interval Between Onset and Death
68760,	ate be executed by sician and in purial-transit purial-transit in the purial-transit in	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):	9		1577		
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burlal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deli	very Day Year
	quires that I n signed by uld be deta	by	Part II. Other significant condition	s contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
I Records,		Completed						24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
of Vital	iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	7	Ott	26. Place of Death (
ō	g Phya er this eral dii	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		HIL 3L DOA	4 Nursing Home	d. Describe how it	e 6 □Other (Spec njury occurred	ify)
ion	ittanding death. ctor: Afte	atio	1 Natural 5 Pending 2 Accident investiga	ition	/ Year) Injury		rk?]Yes 2 □ No			
Division	al or Att after de i Diract d in by t	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, s c. (Specify)	treet, factory, office	28	f. Location (Street City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funarel Director After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or i	th occurred at the tinvestigation, in my o	me, date and place, an opinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the vithin To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number	29d.	Date signed (Month	, Day, Year)
)	^		TAST			D-	4.399		4/15/05	
	٦,		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Type	orth P	4,399 ant Blui	STE 72	4 Bol	to, MD +
	Sta Registr		31. Date filed (Month Par Year)	2005 32. Hegistra	ar's Signature	parte			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie \mathfrak{pe} () 5- State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Collins 14 2005 2:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimute Inder 1 Year I If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Johns Honkins 5. Social Security Number Date of Birthplace (State or Foreign
 Country) **Funeral M** 2□F Months Director 10a. State City, Town or Location 10d. Inside City Limits 10b, County or Items 23s or 28e-f show the Medical Exact net count be notified at 1 Ses 2 No Funeral Director MOI 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 4 Divorced 3 Widowed 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene int: If item 27 Is marked other then ' College (1-4or 5+) other traumatic event, Name (First, Middle, Last) Ohr ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 20a. Method of Disposition 20b. Place of Disposition (N 1 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) permit. Pagé Department of Importent: If eny injury or once. injury or 21. Signature of Funeral Service Licensee P 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure 1 month /Medical Due to (or as a consequence of) Examiner Parumonia 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed H => 15 years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hepatitis with 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Cirrhosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Mnpatient Other: 2 2 X No 1 TYes 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Grette Brown M.O., Ph.O. 265-000 14,2005 April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) APR 1 9 2005

Brown. Johns Hopkins Haspital. Goo North Wolfe Street . Baltimore

32. Registrar's Signature

21287

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 16 2005 7:45 A STEPHEN ALEXANDER COOK, SR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL 678 ST. GEORGE'S AVENUE GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months) Days Hours Min. 10/15/1942 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months MARYLAND XXM 2□ F 62 Director 212-42-0702 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director GLEN BURNIE MD ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 678 ST. GEORGE'S AVENUE 21061 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 No Specify: BLACK 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 LAW FIRM MAIL CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be it of Health and Mental STEPHEN ALEXANDER COOK HARRIETT JANE KEYS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4719 NEW TOWN ROAD, OWINGS MILLS, MD 21117 MR. MAURICE COOK - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or 4/21/2005 GLEN HAVEN GLEN BURNIE, MD * 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. une of Euneral Service Licensee 21. Signa 1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061 mo1120 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** -O Romany /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conse Examiner The law requires that the death certificate be executed as the burial-transit interio and that initiated events resulting in death) Last the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No has page 2 1 Yes 2 No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Yeer)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29c. License number

D20215

29d. Date signed (Month, Dey, Year)

State of Maryland / Department of Health and Mental Hygiene 1 5

				State of Mar	yland / Depa	artment of	f Health a	nd Mental Hy)5	3 43
			amend item #10f per 1. Decedent's Name (First, Middle, Last)	fh g843 5	√19/05 J	Tillcate C	Dealli	2. Dete of De			Time of Death
	Physici /Medic		Myrtle Marie	Coale				APRIL		Sear 3	18 Am
2	Examir		4e Fecility Neme (If not institution, give s				4b. City, Tow Be1	n, or Location of Deetl			
			Lorien - Bel Air 5. Social Security Number 6. Sex		In yrs. lest birthday)	If Under 1 Ye			HAR	9. Birthplace	(State or Foreign
	Funeral Director			M OKIE	90 Yrs.	Months De	ys Hours	Min. (Month, Da Mar. 2	4, 1915	Country) Maryl	
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	r 28a-	Director	Maryland Harford 10e. Street end Number		per At	10f. Zip Cod	le		10g. Citizen of V	What Country?	
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	er daa	Funeral		Was Decedent Event Armed Forces?	er in U,S. 13.	Was Decedent f Yes, specify C	of Hispanic Orig Juban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		e - American Ir ck, White, etc.	ndian,
20	be filed within 72 hours after death with the Manyland ital Hyglene. d other than *naturel', or ferme 23e or 28e-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Merried 2 ☐ Married 3 Æ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1⊡Yes 2√∑i	No Specify:		Specify	whi.	te
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au	rould be filad within 3 Mental Hygiena. nerked other than netic event, me Ma	To Be		Riley			Emm		Beckley	,	
Maryland 21215-0020	d 2 should be th and Menta 7 Is marked traumatic ex	F	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Maili	ng Address (Str	reet and Number	r or Rural Route Numb	er, City or Town,	State, Zip Cod	le)
	CHNL	- 1	Thomas D. White	Son	617	Loight	Road, A	bingdon, M			
Baltimore,	S - P -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R			natory or other	piace)	Date	20c. Location -		
Εij	parmit. Page Dapartment of Important: if any injury or once.	- 1	4 □ Donation 5 □ Other (85ecity) 21. Sign ture of Funeral Service License		THE RESERVE OF THE PARTY OF THE			ns 4–16–05		r, Mary	Land
Ba	Dape Impo	- 9	14/1/2					Home, P.A			21,000
			23a. Fat1. Enter the disease, or complications, or heart feilure. List only on	eations that caused th	e death. Do not ent	er the mode of	dying, such as d	Road, Abin ardiac or respiratory a	rrest,	Apr	proximate erval Between
	Physician		4	Gadao on gada into.							set and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		2/20		ME				
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V	The law requires that the death cardificeta be executed sta has been signed by the ettending physician and page 2 should be dateched for usa as tha bunal-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate	Du	e to (or es a consec	juence of):					
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687	ficeta physi as tha	edical	that initieted events resulting in death) Last	Du	e to (or as e conseq	uence of):					
Вох	eath cartific ettending p I for usa as	Mar									
. H	e deat he ett ned fo	Sicia	Part II. Other significant conditions con	ributing to death but r	not resulting in the u	nderlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
P.0	that the de led by the e dateched	by Physician/M	RENAL FAILURE	HYPOTH	YROIDIST	7		1□	Yes 2□ No	3 Probably	y 4 Tunknown
ds,	uires tha signed ald ba dal	d by			**************************************			24a. Was	en autopsy		utopsy findings
Records,	aw require ts bean si 2 should I	Completed						perfo	omed?	comple of deati	le prior to tion of cause h?
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6	Physician: this certific ral diractor,	은	1 ☐ Yes 2 No 27. Menner of Death	1 ☐ Inpatient 28e. Dete of Injury	2 ER/Outpetier	IL 3L DOA		sing Home 5 Resi	dence 6 □Oth how injury occur		
	After After funa	tlon	1XNaturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(ear) Injury		njuryat Work? 1 ⊡ Yes 2 ⊡ N				
Division	or Attending after death. Director: After I in by the funa	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str	eet, factory, offi	ice	28f. Location (City or To	Street and Numb wn, Stete)	per or Rural Ro	ute Number,
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_	within To the	Me	29b. Signature and title of certifier	111		29c. Lic	ense number		29d. Date signe	d (Month, Day,	Year)
) Cal	lleyfa	u MI	2	14534	4	04/14	1/2005	,
_	-		30. Name and address of person who con	npleted cause of deal	th (Item 23a) (Type,	Print)			,	•	
			SURESH DHANTAN 31. Date filed (APP)POSI Year/2005	Projetrer's	Signature -	N AVE	HAVRE	DE GRACE,	MD210	18	
4	Sta Registr	200	Hrk 1 9 2005	Blogger	15 1500	The same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:00 pm M Anna Harrison Cox April 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Fairhaven Health Care Center Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Yrs. 1915 Director 462-76-9155 90 VA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28e-f show the Medical Examiner roust be notified at MD 1 ☐ Yes 🏋 ☐ No Carrol1 Sykesville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 2 any any injury or other traumatic event, the Mcdcal Examinar contents any injury or other traumatic event, the Mcdcal Examinar contents. Funeral 7200 Third Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Burr Powell Harrison Louise Goldsborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reverend James S. Cox, Jr. (Son) 2308 S. Sherwood Drive Valdosta, GA 31602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Union Cemetery 4/16/2005 Leesburg, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HAIGHT FUNERAL Sykesville, MD HOME & CHAPEL, PA (Box 195) 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Discore Atherosolashis Immediate Cause (Final disease or condition resulting in death) Caranny 10713 **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (vi as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₽ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. after death. 2 Accident investigation the 6 Could not be determined 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Division of Vital Records.

> State Registrar

completely

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Most 1. Man.

(Check only one)

32. gistrar's Signature APR 1 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Mais

29c. License number

032882

Carte D.

29d. Date signed (Month, Day, Year)

			For State Registrer	State of I		d / Depa		lealth ar	nd Mental Hy	giene 20 ()5 3 45
			Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Nicholas	Ciar	a				april	1 40	5 640 AM
	Examin		4a. Facility Name (If not institution,	, give street and number	er)		4b. City, Town, or	Location of I		4c. County of	
Т			Mercy	Hospice				ltimor			
ı	Funeral Director		5. Social Security Number 084-42-2280	6. Sex 7. 1 X M 2 ☐ F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day	y, Year) 18,1950	9. Birthplace (State or Foreign Country) NY
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c City	r, Town or Lo	cation				10d. Inside City Limits
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	the h	Director	MD Balt 10e. Street and Number	imore		Keist	erstown 10f. Zip Code			10g. Citizen of Wh	nat Country?
	3a or		3 Johnsboro Co	urt				1136		USA	
	death	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	<u> </u>		n? (Specify Yes or No- Puerto Rican, etc.)		- American Indian,
336	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show edical Examinat must be netitized at		1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	ied Armed Force ied 1 ☐ Yes 2] If Yes, Give Year or Date	∑ No		1 ☐ Yes 2X No	Specify:	-uerto nican, etc.)	Specify:	White, etc. White
Maryland 21215-0036	72 hor	Completed by	15. Decedent (Specify only highes			16a. Dece	dent's Usual Occup	ation	f working	16b. Kind of Busi	ness/industry
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٥	m O L.		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1.(8		dge Ceme		/15/05	Pikesv	ille, MD
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service) 1		2. Name and Addres		-		erstown Road
B	Den den gen gen gen	5 1	Sleph	on my	July	ns E	Cline Fund	eral H		sterstown	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death	Do not ent	er the mode of dyin	g, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between
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	ed sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to [or	as a consequ	neuce of):					
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):					
09/	ate be executed hysician and the burial-transit	caiE									
89	ificate g phy as the			U			William Town				
Вох	death certificat e attending phy d for use as th	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregna h 2 □ Fetal		Ectopic pregnancy	,		23d. Date	
	0 0 0	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		it at time of de		Other (specify)			Monti	h Day Year
Р. О	at the de d by the a etached t	Phy	9 ☐ Unknown Part II. Other significant condition	_		ultina in the u	adarhilas anuan suu	on in Dout I	220 Did to	nhacoo usa contrib	oute to the cause of death?
ds,	The law requires that the te has been signed by th rage 2 should be detache		raith. Other significant conduct	ms contributing to deat	iii bat not rest	atting at the d	nderlying cause giv	en a raiti.			Probably 4 Unknown
Ö	w requ	etec							-	**	
Records,	has be 2 s	Completed							24a. Was autop	osy pri rmed?_ de	ere autopsy findings available or to completion of cause of ath?
_		e Co	25. Was case referred to medical					00 01		20 No 1	☐Yes 2☐No
Vita	Physician: this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inp	atient 2 🗆	ER/Outpatier	nt 3 DOA Oth	05	f Death (Check only o ing Home 5 ☐ Resid	_	(Specify) home
Ö		H .	27. Manner of Death	28a. Date of I		28b. Time o				now injury occurred	
0	Attanding ir death. actor: After by the funer	atlo	Natural 5 Pendin investig	gation	Day (Gai)	Injury		Yes 2 □ No			
Division of	I or Attanc after death Diractor: I in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	ZXA PIACA OI	Injury - At ho	ome, farm, str	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	ital o									_	
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier Certifyin (Check only one)	ng Physicien: To the be Exeminer: On the basi and manner	is of examinat	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and mant date and place, an	ner as stated. d due to the cause(s)
	To ti withii To ti comp	M	29b. Signature and title of certifier	^			29c. Licens			1	(Month, Day, Year)
	1.11		> 2 ~ 1 ~) m			D	4089	54	411	312005
ij	0'	==	30. Name and address of person	Cicolor.	CAA	20	1 4 Par	1 61	Baltin	٥٧ 21	202
***	Sta Registr		31. Date filed (Month, Day, Year)	9 2005 32. Reg	trar's Signa	ture	forte				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** NATHANIEL DEAN カロ 9 2005 4c. County of Death APRIL 11:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON.
Social Sequence Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. BALTIMORE 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex 1⊌M 2□F Months Days Min NA Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at BALTIMORE Yes 2 No MA Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #15T. U.S. A. 21341 373 or items 23e 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: → Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Be Completed by Specify: ASIAN 3 Widowed 4 Divorced "naturei" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 1s marked other than ury or other traumatic event, the Ma Elementary/Seqondary (0-12) Coffege (1-4or 5+) NIA NA NIA NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DU XIADZHEN HAIYAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23 BAlto 30 21211 MAIYAN Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition .1 ☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any injury or Dulancy Valley ' 4 ☐ Donation 5 ☐ Other (Specify) MONIUM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARTLEY Miller - STELLA CHTD. FUNERAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of): Examiner alow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physician and s the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ■ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month Year in the past 12 months? 1 ■Yes 2 □ No 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) De038718 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21204 Helou 701.N.Charles Sabah 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

APR 1 9 2005

BOY XIAOZHEN

			1 - For State Registrer	State of M	aryland / Depa <i>Ce</i>	artment of Heartificate of De			ene 00	5 13147
	Physicia	an	1. Decedent's Name (First, Middle	-			2	. Date of Death Month		3. Time of Death
	/Medic		Richard Edwa					APR.	16, 200	
	Examin	er	4a. Facility Name (If not institution		,	4b. City, Town, or Lo	ocation of Death		4c. County of	
	Funeral		Gilchrist Hosp 5. Social Security Number		ge (In yrs. last birthday)		Under 24 Hrs. 8	. Date of Birth	Baltimo	Birthplace (State or Foreign
н	Funeral Director		199-14-6880	1 ∑ M 2□F	78 Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Pennsylvania
	pc ,		Usual Residence of Decedent		I do a City Town and					
	shov	5	MD Balti	more	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	
	with Ba or	Ö	208 Kerria La	ne		21220	1		USA	at Oddinity.
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, I		fy Yes or No-	14. Race -	American Indian,
9	be filed within 72 hours after death with the Maryland that Hygiene. So other than "natural", or ttems 23a or 28a-f show avant, the Medical Examinat must be notified at avant, the Medical Examinat must be notified at		1 ☐ Never Married 2 🔀 Marri	Armed Forces' ed 1 XYes 2 ☐ If Yes, Give	No Navy		Mexican, Puerto Al S <i>pecify:</i>	can, etc.)		White, etc. white
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						
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12	within iene	Completed	Elementary/Secondary (0-12) 11	College (1-4or	5+)	intenance			Westingh	nouse
שָׁנ	e filed within al Hygiene. I other than " vant, the Me	Be C	17. Father's Name (First, Middle,	_ast)		18	3. Mother's Name (First, Middle, M	faiden Sumame)	
Maryland	2 should be i and Mental I Is marked o raumatic ava	70	Elmer Dymond		<u> </u>		Eltha Ev			
lar			19a. Informant's Name/Relationsh			ng Address (Street and			-	
	of Health of Health litem 27 l		Richard A. Dymo	ond - Son	20b. Place of Dispo	Beechfield	d Ave., E		e, MD 2_ 20c. Location - Cit	LO75
סַר	ages nt of h :: If ite		1 ⊠ Burial 2 □ Cremation		cemetery, cre	matory or other place)			Elkridg	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		* 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Fun In Service I			lge Mem. Pk 2. Name and Address o				
Ba	Depa Impo any ii		Media			ry L. Kauf 250 Washing				wridge MP, Inc.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do not en	ter the mode of dying, s	such as cardiac or	respiratory arre	ist,	Approximate Interval Between
	Physician	5 1	Immediate Cause (Final disease or condition	i Lan	g Cance	A.				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of);					7
4	Examiner	L.	Sequentially list conditions,	b. — Due to for as	s a consequence of):					
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9	the death certificate y the attending phys iched for use as the	Medi	IF FEMALE:							
Вох	eath certific attending p I for use as I	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of	•
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	t time of death 5	Other (specify)				,
P.0	that the di		Part II. Other significant condition	ns contributing to death I	but not resulting in the u	nderlying cause given i	in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?
rds	quires n sign	d by						1 X Ye	s 2□No 3[Probably 4 Unknown
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Re	The lav ate has page 2	mo						autopsy perform	ned? dea	r to completion of cause of th? Yes 2□ No
Vital		BeC	25. Was case referred to medical examiner?			20	6. Place of Death (/	
Ž V	Physician: this certific ral director,	ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati		the second secon	4 🗆 Nursing Home			(Specify) hospid
o uc	ing After une	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin		ury 28b. Time o ay Year) Injury	Work?	t 28 s 2 □ No	d. Describe ho	w injury occurred	
Division of	I or Attanding after death. I Director: After din by the funer	ficat	2 Accident investig	ot be 200 Blood of In	ijury - At home, farm, st			f. Location (Str	eet and Number	or Rural Route Number,
2	in Ite	Certification;	4 Homicide determ	building, e	tc. (Specify)	,,,		City or Town	, State)	
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifyin 2 Medicel	g Physicien: To the best Exeminer: On the basis of and manner s	of examination and/or in	h occurred at the time, vestigation, in my opini	date and place, an ion, death occurred	d due to the ca at the time, da	use(s) and mann ite and place, and	er as stated. I due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	0		29c. License ni		29	d. Date signed (/	Month, Day, Year)
)			Meran	Soul		058		į į	April 7	7 2005
	SX		30. Name and address of person	11.01	death (Item 23a) (Type,	Print)	itune !	~ 2	1204	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Regis	ar's Signature	1.1.			1	
	Registr		APR	1 9 2005	become to	Goode				

Dymond, Ectived C. 4110/25 @ 2125

			1 - For State Registrar		Marylar		artmen <i>tificat</i>		ealth and Death		Reg. No.	2005	10170
	Physicia	an	1. Decedent's Name (First, Middle, La Lucy Elizabea		Piis					2. Date of De	ath Day	2005	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gir				4b. City.	Town, or	Location of Deat	April		County of Dear	10:38 P M
	Examin	er	Stella Maris		,			moni				Baltin	nore
	Funeral		5. Social Security Number 6.		7. Age (In yrs.		If Under Months	1 Year	If Under 24 Hrs Hours Min.	8. Date of Bir	th y, Year)	9. Bir	thplace (State or Foreign
	Director		214-01-5554 Usual Residence of Decedent	1□ M 21 F	88	Yrs.				July 2	7, 1	916 Neu	york
	/land		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	Mary a-f sh	tor	Maryland Baltin	nore		Bal	timor	e					1 ☐ Yes 2 No
	with the Maryland a or 28a-f show	Director	10e. Street and Number		<u>_</u>		10f. Zip	Code			_	zen of What Co	ountry?
	s 23a	rall	8017 Babikow Ro	,					21237			.S.A.	
=	ter de litems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece Armed Fo 1 ☐ Yes	rces?	J.S. 13.	Was Deced f Yes, spec	lent of Hi cify Cuba	spanic Origin? (S n, Mexican, Puer	ipecity Yes or No to Rican, etc.)	-	14. Race - Ame Black, Whit	
р•ш	036 ours aff	ρ	3 XWidowed 4 □ Divorced	If Yes, Giv Year or Da	e ates:		1 🗆 Yes	2 💢 No	Specify:			Specify: W	rite
20	d 21215-0036 filed within 72 hours after death with the Maryland Hygien. Hygien and naturel, or Items 23a or 28a-f show ont, the Maryleal Everylity Intest to Indificed at	Completed	15. Decedent's E (Specify only highest gi			16a. Deced	dent's Usua kind of wo	al Occupa	ation furing most of wo	rking	16b. Ki	nd of Business	/Industry
10:	within one.	mp	Elementary/Secondary (0-12) 6th Grade	College (1	-4or 5+)		00 NOT U)		C	lothing	
	d 2 filled Hygie other ent, the	e	17. Father's Name (First, Middle, Las	t)		Jeu	msoce	23.23	18. Mother's Na	me (First, Middle			
2	aryland 2121 should be filed within and Mental Hygiene. s merked other then " umatic event, Ire Ma	To B	Lebo DiBennez	ti					France	esca	Sac	cone	
2005	0 0 0 0		19a. Informant's Name/Relationship		,		-		and Number or Ri				
	re, M s 1 and 2 f Health item 27 other tra		Mr. Joseph DeJul 20a. Method of Disposition	us (son)				'l Drive,	Date		h, MV cation - City or	21162
14,	Baltimore, I permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		1 XBurial 2 ☐ Cremation 3 [วเลเย	Place of Dispo cemetery, crer							Maryland
Apri1	nit. Parantme ortant injury		4 □ Donation 5 □ Other (Spec21. Signature of Funeral Service Lice		1 00	ırdens 22			is of Facility Sch				
Арл	Balti permit. Departi Importa any inji		Buen a. le	riller)	9	705 B	elai	r Rd., 1	altimor	e, Mi	21236	les
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	/Medical Examiner		resulting in death)	Due to	or as a conse	quence of):							
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	Box 6	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		-17 1112-0				2	23d. Date of de	livery
	death death e atte	icia	in the past 12 months? 1 Yes 2 No	4 ☐ Pregn	irth 2 Feta ant at time of		Ectopic pr Other (sp					Month	Day Year
is	P.O.	Phys	9 🗆 Unknown	9□ Unkno									
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eju	cord w require been si	eted								24a. Was		1	A.
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Lucy		a	25. Was case referred to medical						26 Place of De	1 ☐ Yes ath (Check only o	2 No	1 L Yes	; 2□ No
Н	of Vil	To B	examiner? 1 □ Yes 2 🗶 No	Hospital: 1 🗆 I	npatient 2	ER/Outpatier	it 3 🗆 DC	Othe		lome 5 ☐ Resi		Other (Spe	cify) HOSPICE
	on of ding Phys h. After this funeral d	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time or Injury		8c. Injury Work		28d. Describe	how injur	y occurred	
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	Division within 24 hours after death within 24 hours after death or to the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 X Certifying F (Check only one) 1 Medical Exa	nysician: To the	best of my kn asis of examin ner stated.	owledge, death ation and/or in	n occurred vestigation	at the tim	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
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				- 12-			17	14	3725		۷	1/15/	05
	b		30. Name and address of person who										
	Sta	to	DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)) DULAN egistrar's Si gn	EY VAL	LEY R	D.	TIMONIUM	, MD 210	193		
	Sta		APR 1 9 20		un B	A TOWN							

		•	For State Registrar		Sta	ate of M	Marylan		artmen rtificate			and M	ental Hy	giene () (05	13149
	Physicia	an	1. Decedent's Nam										2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Waldi		vado		-		41 63	-	1	(5 - 1)	April		2005	430 PM
	Examin	er	4a. Facility Name (,			S fow		·	1	ty of Death	
	Funeral		5. Social Security I		6. Sex			last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	h		lace (State or Foreign try)
	Director		None		1□ M 2	F	100	Yrs.	Months	Days	Hours	Min.	(Month, Da March	6,1905	Colo	ombia
	pg 🛾 🖢		Usual Residence of	f Decedent 10b. County			10c Cit	y, Town or Lo	neation						1	0d. Inside City Limits
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	the h	rect	10e. Street and Nu		11101 6	-		TIGID	10f. Zip					10g. Citizen of	What Coun	try?
	h with	Funeral Director	124	27 Dip	loma D	rive				21:	136			Co	olembi	.a
	ems a	ner	11. Marital Status		12. W	as Decede	nt Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ice - Americ ack, White,	
36	s after, or it	by Fu	1 ☐ Never Mar 3 🛣 Widowed		lf '	med Force □Yes 2 [Yes, Give			Yes 2				ombian	Speci		hite
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212	d with glene ar the	mo:		2		2 2		Te	eacher					Gove	rnment	
p	oe file ta! Hy d oth	Be	17. Father's Name										(First, Middle,		те)	
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Baltimore,	mit. I partm sortei y inju	İ	21. Signature			a	1	22	Name an	d Addres			Chapel,			
ñ	Pe e e		14	4.2	Melle	ad	1		11605	Rei	ster	stow	n Rd.	Owings	Mills	. Md. 21117
8760, <	Fringician / Medical Examiner bulkician and bulkician and sthe purial-transit	dicai Examiner	Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death)	on onditions, mmediate erlying r Illijury	b	OMP Due to (r	as a consequence as a c	uence of):								Onset and Death
.O. Box 6	the death certify the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months? ☑No	1(Live birth	me of pregna 2 ☐ Feta at time of d	I death 3	Ectopic pro						ate of delive	ry Day Year
<u>α</u>	res that signed by be deta	by Ph	Part II. Other sign	ificant conditi	ons contribut	ing to death	n but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco use cor	ntribute to th	e cause of death?
Vital Records,			lung	mass									1	res 2 ⊠No	3 Prob	ably 4 □Unknown
900	ie ław requ has been je 2 shouli	Completed											24a. Was			osy findings available inpletion of cause of
m m	The ate h page	Com											perfo	rmed?	death?	210 No
/ita	i icien: Th certificate rector, pag	Be	25. Was case refe examiner?	/	Hospita	1.				Othe		of Death	(Check only o	ne)		
oţ	ing Phys	tion: To	1 ☐ Yes 2 ☑ 27. Manner of Dea 1 ☑ Natural 2 ☐ Accident		28a	1 ∐ Inpa a. Date of li		ER/Outpatier 28b. Time of Injury		8c. Injury Work	at	4	ne 5 🗌 Resid 28d. Describe h			')
Division	el or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 4 Homicide	6 Could detern		e. Place of building,	Injury - At he	ome, farm, str fy)	eet, factory	, office			28f. Location (S City or Tow		ber or Rura	l Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled it	edical	29a. Certifier (Check only one)	1 ☑ Certifyii 2 ☐ Medical	Examiner: C	: To the be in the basis nd manner	s of examina	owledge, death ation and/or in	h occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the dead at the time,	cause(s) and m date and place	nanner as st , and due to	ated. the cause(s)
	To t	Σ	29b. Signature and	d title of certifie	o 1.		A			. License				29d. Date sign		
•			1	0)	7	7)	-/UC	,		100	605	0+		April 1	0,20	02
	2		30. Name and add	Mejia	S401	010	court	Road	Print) Ranc	lalis	town	, Ma	yland	2113	3	
	Sta Registr	45. 6	31. Date filed (Mo	HPR YIar	9 2005	32 Regi	strar's Signa	B A	and i							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** DECKER 7:10 A M APRIL CATHERING 14 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CONTER HARBOR HUSPITAL 8. Date of Birth (Month, Day, Year) Feb. 9, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Director 216 42 4441 59 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or Items 23a or 28a-1 show traumatic avant, the Medical Exominat must be notified at 1 X Yes 2 □ No Mary1and Directo N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 1324 Washington Blvd. 21230 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thelma White Earl Decker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nrit. Pages 1 and 2 orthealth a certaint: If item 27 is njury or other tra David Saffran 1324 Washington Blvd. Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4/18/2005 Baltimore, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) Gonce Funeral Service, F.A. permit.
Departr
Importa
any nji 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 namusally wyne 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final STROKE Pnysician 70AYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner I Days SEPSIS METHICILLIN RESISTENT STAPHYLOCOCCUS AUREUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit 15 DAYS THROMBOCY TO PENIA HEARIN INDULOR resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 certificate be NON SMALL CELL LUNG CANCER Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☑ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 12 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of assignment and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL MD 14 RES 000 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. HANOVER STREET, BALTIMORE, 21225 MO MARKANDAYA MANJUNATH 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2005 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland / I		artmeni <i>tificate</i>			and M	R	eg. No.	05	13151
	Dhusisi	-	Decedent's Name (First, Middle	e, Last)							Date of Deat Month		Year	3. Time of Death
	Physici /Medio		Lillian F.	DePetris							April	17,	2005	11:00 p M
	Examir		4a. Facility Name (If not institution	, give street and numi	ber)		4b. City,	Town, or	Location of	of Death		4c. Count	y of Death	
			Continuum Ca		sville				kesvi			Car	roll	
	Funeral Director		5. Social Security Number 214-05-3663 Usual Residence of Decedent	6. Sex 7 1 ☐ M 2 🖾 F	. Age (In yrs. last bi	rthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birth (Month, Day, Sept. 3	Year)	9. Birthi	place (State or Foreign ntry) MD
	and and		10a, State 10b. County		10c. City, Tow	vn or Lo	cation							10d. Inside City Limits
	Be-f sho	ctor		timore		R	eiste		wn					1 ☐ Yes 2 🛣 No
	or 2	Dire	10e. Street and Number				10f. Zip				1	0g. Citizen of		ntry?
	ath v	la l	1633 Oakland				J		21136				S.A.	
21215-0036	gas 1 and 2 should be filad within 72 hours aftar death with the Maryland it of Health and Marial Hygiana. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Modical Example in the Indifficult at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2	2 X No		Was Deced fYes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)		ce - Ameniack, White,	
5-0	72 hc	Completed	15. Decedent	t's Education	16a	. Deced	dent's Usua kind of wor	l Occupa	ation	t of working	10	16b. Kind of 8	Business/In	dustry
21	thin and	ple	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. L	DO NOT us	e retired,)	or workin	'9			
S	ad wi	Son	9				Tail	or				Le	bow B	rothers
nd	al Hy	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle, I	Maiden Suma	me)	
Va	Mant Mant Prked	2	Anton Srb						Ros	se Va	cek			
Maryland	12 should be filad within h and Mantal Hygiana. 7 is marked other than "raumatic event, It a Man		19a. Informant's Name/Relations	hip (Type, Print)	198	b. Mailir	g Address	(Street a	and Numbe	or Rura	Route Number	City or Town	, State, Zip	Code)
	1 and Haatth am 27 ther tr		Donna Gosnel	1 Daughte			33 0a		d Roa		Reister	stown,	MD 2	1136
ore	of Haritan		20a. Method of Disposition 1 X Burial 2 Cremation	2 Pamoval from St	20b. Place o	of Dispo ary, cren	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Location	- City or To	own, State
Ĕ	Pagas nant of I ant: If its ary or o		`4 □Donation 5 □Other (S		Morel	and	Mem :	Park	4	/20/	05	Parkvi	11e,	Maryland
Baltimore,	permit. Pagas Dapartmant of Importent: If i any injury or once.		21. Signature of Funeral Service	Licensee	2		. Name an							own Road d. 21136
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car	used the death. Do	not ent	er the mode	e of dying	g, such as	cardiac o				Approximate Interval Between
	Physician /Medical	Ì	Implediate Cause (Final disease or condition resulting in death)	-a. En	d Stage r as a consequence		nenti	4					(Onset and Death
	Examiner			0) 01 600	as a consequence	01).								
	ad sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a consequence	of):								
oʻ	aath cartificata be axecutad attanding physician and for usa as tha burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):								
3760,	ata be hysici iha bu	Ilcal		d										
39)	ing pl	Med	IF FEMALE:											
P.O. Box	The law raquiras that tha death cartificata be axecuted tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live bir	ome of pregnancy th 2 Petal death nt at time of death vn		Ectopic pro Other (sp						ate of delive onth	ery Day Year
rds, P	w raquiras that been signad to should ba data	þ	Part II. Other significant condition	1001	th but not resulting	in the ui	nderlying ca	ause give	en in Part I.		23e. Did tob			he cause of death? pably 4 [Unknown
I Records,	ding Physician: The law raqu h. Attar this certificate has been funaral cirector, page 2 shoult	Completed		·							24a. Was a autops perform	у "	Were auto prior to co death? 1 \(\text{Yes} \)	ppsy findings available mpletion of cause of 2 No
/ita	stan: artific ctor,	Be (25. Was case referred to medical examiner?	and the second second						of Death	(Check only on	9)		
of Vital	Physician: this certificatal cirector, participate in the control of the control	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ In	patient 2 ER/O	utpatien	t 3□ DO	A Othe	9F: 4 Nu	rsing Hon	ne 5 🗆 Reside	nce 6 🗆 Ot	her <i>(Specit</i>	y)
	ng Pl		27. Manne of Death 1 ■ Natural 5 ■ Pendin	28a. Date of (Month	Injury 28b.	Time of Injury	2	8c. Injury Work	at ?	2	8d. Describe ho	w injury occu	rred	
0	Attanding ir daath. actor: Aftarby the funa	atle	2 Accident investig	gation			М	1 🗆 \	Yes 2 □ I	No				
Division	al or Attano after daath I Diractor: d in by tha	Certification:	3 Suicide 6 Could a determination	inca 280. Place o	of Injury - At home, fa g, etc. <i>(Specify)</i>	arm, str	eet, factory	, office		2	8f. Location (St. City or Town		ber or Rura	al Route Number,
	To the Hospital or Attanc within 24 hours after daath To tha Funeral Diractor: complataly fillad in by tha	Medical (29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	sis of examination ar	e, death	occurred a	at the lim in my op	e, date an pinion, dea	d place, a	and due to the ca	use(s) and mate and place,	anner as s , and due to	tated. o the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifie	1 /11	//		29c	. License	number		2	9d. Date sign	ed (Month,	Day, Year)
	N	1		1100	1 MD			1)2	33186	1		Hool 1	820	U5
6	101		30. Name and address of person	who completed cause	of death (Item 23a)	(Type.	Print)	(Ih	th	Dain	Rex	to trus	M	2/136
-9	Sta Registi		31. Date filed (Month, Day, Year)	2005	gistrar's Signature	4	ale	(4	-1 ¥	N. I.A.	1-(1)		(

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			State State Ragistrar	of Maryland / Depa Ce	artment of He		ental Hygie Rag	2000	13152
			Decedent's Name (First, Middle, Last)				2. Date of Death	. NO.	3. Time of Death
	Physicia	an		ELLIOTT			Month	Day Year	7:10A M
	/Medic		7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		4h Ciby Town as 1		PRIL 19	4c. County of Death	
	Examin	er	4a. Facility Name (If not institution, give street and n		4b. City, Town, or I				
				25/19 Home		If Under 24 Hrs. 8	Date of Birth	BALT	
	Funeral		100 000	7. Age (In yrs. last birthday) Yrs.	Months Days	Hours Min	B. Date of Birth (Month, Day, Yo	earl Cor	place (State or Foreign Intry)
	Director		Usual Residence of Decedent	16		/	harch 16,	1757	100.
	and and		10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
	Aaryl shc	ō	MD BALTIMORE	€	PARKVILLE				1 ☐ Yes 2/☐ No
	28a-	Director	MD BALTIMERE 10e. Street and Number		10f. Zip Code		100	. Citizen of What Cou	•
	with a or	Ę				234	109	U.S. A	•
	s 23	Funeral		cedent Ever in U.S. 13.			4. V N.	14. Race - Amer	
	er de itam	nu	Armed I		Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto R	ican, etc.)	Black, White	
36	; or	by F	1 Never Married 2 Married 1 7 es 17 Yes, C Year or	2 No U.S. Sive Dates: ARM	1 ☐ Yes 2 No	Specify:		Specify: W	TE
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene, of chart than "natural", or itams 23a or 28a-f show do that than "natural", or itams 23a or 28a-f show avant. The Medical Examinat must be notified at	pa	15. Decedent's Education		edent's Usual Occupat	tion	16	b. Kind of Business/li	
<u>.</u>	n 72 "na edic	Completed	(Specify only highest grade completed	f) (Give	e kind of work done du DO NOT use retired)	uring most of working	7	b. Kind of Businessyll	idustry
12	withi ene. than	щ	Elementary/Secondary (0-12) College	(1-4or 5+)	Service i			Proving	Generals
	Hygie Hygie othar	ပိ	17. Father's Name (First, Middle, Last)			18. Mother's Name (6100,-00.
Maryland		o Be	Peelverone LLIOTT			ELLEN			
$\overline{\leq}$	d 2 should th and Men 7 Is marka traumatic	ř	19a. Informant's Name/Relationship (Type, Print)	19b Maili	ing Address (Street ar				n Code)
Ma	オイトコ		D 011 1		4 4		^		
	s 1 and 3 f Health Itam 27 other tra		20a. Method of Disposition	20b. Place of Dispo	& BIRMING	Da		c. Location - City or T	
ية	of of		1 ☐ Borial 2 ☐ Cremation 3 ☐ Removal from	n State cemetery, cre.	ematory or other place,	1			
			'4 □ Donation 5 □ Other (Specify)	Holly Hill	lls cem.	10110	S MI	oole River	MD.
3al	permit. Departn Imports any inju		21. Signatury of Funeral Service Licensee	2	2. Name and Address	STEU	A FUNCENI	HOME CH	. עד
	0 0 = # 0		faul Tri. Jul	7	527 hartor	O FD 130	1170.100	21834	
и.			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on immediate Cause (Final	each interest and the death. Do not en	iter the mode of dying,	, such as cardiac or	respiratory arrest		Approximate Interval Between
1	Pnysician	ĺυ	Immediate Cause (Final disease or condition	5 4253201	14 242(31	24%	7 5 MESS		Onset and Death
	/Medical		resulting in death) Due to	o (or as a cons					
	Examiner		Sequentially list conditions, b.	11-12	270 20(23)	6 42			
	D =	ner	tary leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a cons⊯uence of):					
>	nd nd trans	Examin	that initiated events c.						
o,	e exe ian a urial-		resulting in death) Last Due to	o (or as a consequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d						
39	ng pl	a a	IF FEMALE:						
Вох	eath certific attending p for use as t	an/I	23b. Was decedent pregnant 23c. If yes, o	utcome of pregnancy birth 2 Petal death 3	□Ectopic pregnancy			23d. Date of deliv	,
Ξ.	dea ne att	Sicia	1 Yes 2 No 4 Pre	gnant at time of death 5[Other (specify)			Month	Day Year
P.0	at the de by the a tached	Physician/M	9 Unknown						
Ś	es tha igned be de	by 6	Part II. Other significant conditions contributing to	death but not resulting in the u	underlying cause giver	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rd	w require been sig should b						1 Tyes	2 No 3 Pro	bably 4 Mnknown
Records,	aw re s bei	Completed	(/3.402612				24a. Was an	24b. Were aut	opsy findings available
R	The lav ate has page 2	ШО					autopsy	d? death?	ompletion of cause of
		a)	25. Was case referred to medical			26. Place of Death (10 105	21,300
5	5 8 E	0 B	examiner?	Inpatient 2 ER/Outpatie	Othor			e 6 □Other (Spec	60
	Phys or this oral di		27. Manner of Death 28a. Dat	e of Injury 28b. Time of	of 28c. Injury	at 28	d. Describe how		.97
on	ading th.: Afte	ilo	1 Accident 5 Pending (MC 2 Accident investigation	inth, Day Year) Injury	Work? M 1 ☐ Y	? es 2 □ No			
Division	Attanding in death. actor: After by the fune.	fice	3 Suicide 6 Could not be 28e. Place	ce of Injury - At home, farm, st	treet, factory, office	28		at and Number or Rui	al Route Number,
Ö	after Dira	Certification	4 Homicide determined buil	ding, etc. (Specify)			City or Town, S	State)	
	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: Atter completely filled in by the funer		29a. Certifier Tertifying Physician: To the	ne best of my knowledge, dear	th occurred at the time	e, date and place, an	d due to the caus	se(s) and manner as	stated.
	e Ho e Fu letely	Medical	(Check only 2 Medical Examiner: On the one)	basis of examination and/or in inner stated.	nvestigation, in my opi	inion, death occurred	d at the time, date	and place, and due	to the cause(s)
	ro th withir ro th somp	Me	29b. Signature and time of certifier	1. 1-0	29c. License		29d.	. Date signed (Month	
			290. Signature and years to spine 1	1 1		1550		4/18/05	
•	3		30. Name and address of person who completed ca	use of death (Item 23a) (Tyne				(
	V		EDDTE NAKHUDA. M.D. 2.	300 DULANEY VA		TIMONIUM	1, MD 21	093	
	Sta	te			The in		,		
	Registr		APK 1 9 2005	Registrar's Signature	and I				

THOMAS ELLIOTT APRIL 18, 2005

			_ TOI	eartment of Health and Meartificate of Death	ental Hygier Reg.	2000 13103
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		AiLeen Eichelberger			6, 2005 2:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			2809 TAYLOR AUC	PARKVIlle.		BATIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday	Months Days Hours Min	B. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		220-22-2531 10M 30F 76 Yrs.	Months Days Hours Minn.	1006,198	18 Country VA.
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	faryli sho	ក	MD BALTIMORE	Parkville		1 ☐ Yes 2 ☑ No
	28e-i	Director	10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
	with Ba or		2809 TAYLOR AVE	21234		U.S.A.
	ours after death with the Marylar ral', or Itema 23a or 28e-1 show Examir or must be notified at	Funerai		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - American Indian,
10	riter	Ε̈́	1 Never Married 2 Married 1 Yes 2 No		ican, etc.)	Black, White, etc.
93	al', o	by	Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or llema 23a or 28e-f show fra M. Jical Examiran Le motificol an	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b	. Kind of Business/Industry
2	d within 73 giene. r than "n	npidu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
	77 75 1 100		1244 NIA	ASSEMBLY		VIETICAN CORP.
and	be d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		
3	2 ≥ 2 2	^L	LAWYER EL HCPNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Ing Address (Street and Number or Rural	A HANS	
Maryland	12 12 7 15 15 15 15 15 15 15 15 15 15 15 15 15			TAYLOR AVE. BAlto		234
	s 1 and 3 f Health item 27 other tra		20a Method of Disposition 20b, Place of Disc	position (Name of Da		Location - City or Town, State
<u>0</u>	0		1 Burial 2 Cremation 3 Hemoval from State	ematory or other place) cod Cem. 4/20	105	Balto. M.D.
Baltimore,			'4 □Donation 5□Other (Specify) € ITTO A BIRETT PARK W	22. Name and Address of Facility	6.04	on Home CHTD
Ba	permit. Departi Importi any inj		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	22. Name and Address of Facility STE HARTIEY HILLER - STE 527 HATFORS RD. BA	the Mo	2137Y Approximate
	Physician /Medical Examiner	er	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Due to (or as a consequence of):	mmil Cell Wi	rz co	Initerval Between Onset and Death
	nd nd transit	Examin	if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
8760,	cate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
687	ficate g phys	edical	0.			
O. Box	at the death certificate be executed by the attending physician and tached for use as the burral-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Ω.	res that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ord	w require been si should I	ted			1 🗌 Yes	2 No 3 Probably 4 Unknown
Vital Records,	The farate has page 2	Completed			24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \) No
Vit	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		_
o	Phys this ral dii	To	1 Tes 2 ENO 1 Inpatient 2 EN/Outpatie	ant 3 DOA 4 Nursing Home	e 5 TResidence 3d. Describe how in	6 □Other (Specify)
	ding I h. After funer	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		ijaly overnou
Division	Attending in death. ector: After by the fune	fica	3 Suicide 6 Could not be	treet, factory, office 28	If. Location (Street	and Number or Rural Route Number,
<u>S</u>	= +	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea control on the basis examination and/or in and manna stated.	ath occurred at the time, date and place, ar investigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature my Mark Cartifler	29c. License number	29d.	Date signed (Month, Day, Year)
•	1)		July Chunn	001249		11.00
ne.	10		30. q and do is of person who plete cause of deat (Net) 23a) the	r. Svite 302	lowson	J, Mg 21204
	Sta Registi		31. Date filed (Month, Day, Year) 9 2005 32. Pogistrar's Signature	South		

		_	For State	1 10000	State of Ma		d / Depa	artmei	nt of H		nd Mental H	-lygien	2005	13154
/M	rsicia ledic amine	al -	1. Decedent's Name SAMUEL 4a. Facility Name (I	WEB		SR.				Location of C	2. Date of Month April	15	ay Year 2005 c. County of Deal	3. Time of Death 2:40 A M
Fune Direc		9	5. Social Security N 217-56-9	863 6. S	ex 7. Ag		ORE last birthday) Yrs.			If Under 24	Hrs. 8. Date of (Month), FEB.	Birth Day, Year 2, 19		thplace (State or Foreign buntry) MD
Maryland a-f show	Med Bi	tor	Usual Residence of 10a. State MD	10b. County			y, Town or Lo							10d. Inside City Limits 1 XYes 2 No
th with the	usi ke nu	Funeral Director	10e. Street and Nur 3800 FER	nber NDALE AV	ENUE	,			p Code 21207			10g. C	Citizen of What Co USA	puntry?
illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show	EXACIDATION	ρ	11. Marital Status 1 ☐ Nøver Marri 3 ☐ Widowed	ied 2⊡ Married 4 ∰Divorced	12. Was Decedent Armed Forces? 1 Yes 2 It If Yes, Give Year or Dates:		i	Was Dece If Yes, spe 1 Yes		ispanic Origin n, Mexican, F Specify:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: BL	e, etc.
within 72 hujene.	I SE MEZICAL	Completed	(Spec	15. Decedent's E cify only highest gra indary (0-12)	ducation ade completed) College (1-4or 5 2	i+)	life.	kind of w DO NOT (ork done d use retired	during most o			Kind of Business,	
2 should be filed within and Mental Hygiene.	tic event,	To Be C	17. Father's Name	(First, Middle, Last EATON)						Name (First, Mic DIE SATT			
Deficiency, Ivaly permit. Pages 1 and 2 sho Department of Health and Inportant: If item 27 Is ma	lury or other traumatic event, in a Mudicial Evaluation of the Configuration of		20a. Method of Disp 1 X Burial 2	CATON/MOT	HER	, c	Place of Dispo cometery, crei	800] esition (Na matory or	FERND ame of other place	ALE AV	ENUE, BA	20c. 1	, MD 212 Location - City or	07 Town, State
Depart Import	any in		21. Signature of Fu	he disease, or com	plications that caused	∠ n the deati		170	l LAU	RENS S	ST., BALT	0., 1		NS F.H., IN
Physic /Medi Exami	cal ner	_	Immediate Cause disease or condition resulting in death)	(Fination	a. Acute Due to (or as	a conseq	epene	r di lent		Infe abëtes	rction me	litu:	5	Interval Between Onset and Death
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and		dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) i	5	c									
Physician: The law requires that the death certificate this certificate has been signed by the attending phys	ached for use as	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2[9 Unknown	months? ⊒No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3	∃Ectopic p ∃Other (s	pregnancy				23d. Date of de Month	livery Day Year
en signed t	and be deta	þ	Part II. Other signif	ficant conditions	contributing to death b	ut not res	ulting in the u	nderlying	cause giv	en in Part !.	1	id tobacco	_	the cause of death?
The law recate has be	, page 2 sho	Completed									a	Vas an utopsy erformed?	death?	utopsy findings available completion of cause of 25 No
viciar siciar certif	recto	Be	25. Was case refer examiner?	P	Hospital:		5010:		Oth	200	Death (Check or		- Clau (a	
nding Physath.	e tuneral di	ation: To	1 Yes 2 27. Manner of Deat 1 Natural 2 Accident		28a. Date of Inju (Month, Da	ry	28b. Time o Injury		28c. Injun Worl	4 Nursi	28d. Descri		6 ☐Other (Spe ury occurred	ciry)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After	iled in by ti	Certification:	3 Suicide 4 Homicide	6 Could not be determined	building, et	c. (Specif	y)				City or	Town, Sta	ite)	ural Route Number,
he Hosp in 24 hou he Fune	pletely fi	edical	29a. Certifier (Check only one)	2 Medical Exa	nysician: To the best miner: On the basis o and manner st	f examina	wledge, deat tion and/or in	h occurred vestigatio	d at the tin n, in my o	ne, date and pointion, death	place, and due to occurred at the tir	ne, date a	nd place, and due	to the cause(s)
To t To t	E 05	Σ	29b. Signature and	I title of certifier					c. Licens				ate signed (Mont	
	4		30. Name and addr	ress of person who	completed cause of c	eath (Iten	n 23a) (Typ <i>e</i> ,		25	-60	6	Apri	115/	2005

State Registrar M OH A MMO U -31. Date filed (Month, Day, Year) APR 1 9 2005

SHARIEF MD

			1 - For State Registrar	State of	Maryland / De	partmen ertificat				giene ()	05	13155
	_		Decedent's Name (First, Middle, Lass)	t)					2. Date of De	ath		3. Time of Death
и	Physici		Helen I	ouise	Errickson	1			April	1 ^{P3y} 20	0 ^{Year}	2:55p M
1	/Medi Examir		4a. Facility Name (If not institution, give	street and num	ber)	4b. City,	Town, or Lo	ocation of Death			ty of Death	2.335
	LAGIIII		Manor Care Ros	sville	2	F	Rossv	ille		Balt	imon	<u> </u>
	Funeral		Social Security Number 6. Security Number		. Age (In yrs. last birthd	Months		f Under 24 Hrs. Hours Min.	8. Date of Bir	th		place (State or Foreign
١.	Director		218-09-6226	□ M ¾ ¾	86 Yrs	·	Days	Hours Mill.	July7	, 1918	Mar	ÿland
	pui *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			<u> </u>			0d. Inside City Limits
	sho	ō	MD Baltimo	re		Ssex					'	1 ☐ Yes 2 No
	the A	Director	10e. Street and Number			10f. Zip	Codo			10g. Citizen of	What Cour	
	with	Di	310 Wye Road				1221				what Cour	itry?
	leath	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S. 1			anic Origin? (Spe	acify Yes or No	USA 14. Ba	ice - Americ	an Indian
' O	riter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Ford	es?	If Yes, spe	cify Cuban,	anic Origin? (Spe Mexican, Puerto	Rican, etc.)	BI	ack, White,	
036	urs a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Da		1 ☐ Yes	2₹ No .	Specify:		Spec	^{⊮y:} Whi	te
21215-0036	72 hours after death with the Maryland Instural, or items 23e or 28a-f show digal Examination multiple at	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. De	cedent's Usua	al Occupation	on	ing	16b. Kind of I	Business/In	dustry
21	C * 38	nple	Elementary/Secondary (0-12)	College (1-	401 3+)			ing most of worki	ng .	Post	Off	ice
21	be filed within 72 hours after death with the Marylan hal Hygiene. Id other than "natural", or items 23e or 28a-f show other than "natural", or items 23e or 28a-f show event, the Maxical Examination of the Max	Co	8th		PC	stal						
Maryland	ihould be filed within dental Hygiene. marked other than maric event, the M	Be	17. Father's Name (First, Middle, Last) Michael Cole				18	B. Mother's Name				
Σ	s 1 and 2 should f Health and Men item 27 is marke other traumatic	2	19a, Informant's Name/Relationship (7	imo Printl	10b M	ailina Addroos	/Ctroot on	F LOY		Eccles		Code
Ma	d 2 sho th and traum		Randy Erricks			_		d Balti				Code)
øĵ.	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	, , , , ,	20b. Place of Discemetery, of	_			Date	20c. Location		own, State
no	ages ent of it: If i		1 ★ Burial 2 Cremation 3 1 ★ Burial 2 Cremation 3 1 ★ Cremation 5 Cher (Specify		Garden			4/20	/05	Rossv	ille	MD
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licen		0.0			1 *	•		7	S -
ñ	Depar Impor any ir		1 K Turn	16000	nelly,	200	Maga	Con Ave.	nellyi	unera	THOM	eofEssex
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	ications that ca	used the death. Do not						D 21.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ESMOUA	Carrie	0.4	A	211			Onset and Death
7	/Medical		resulting in death)		r as a consequence of):	>600	11/1	11/2	MJC			3 112
	Examiner		Sequentially list conditions	b								
	ם יו	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequence of):							
\$	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	cate be executed physician and the burial-transit	E		Due to (o	r as a consequence of):							
68760 ₂ 9		dical		d								
	death certific e attending p id for use as	Physiclan/Me	IF FEMALE:	23c. If yes, outc	ome of pregnancy					234 D	ate of delive	nn/
Вох	atter for u	clan	in the past 12 months?	1 Live bir	th 2 Fetal death	3 □Ectopic pr 5 □ Other (sp					onth	Day Year
o.	0 00 0	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknov		(54.5			
σ.	The law requires that the tee bas been signed by thoage 2 should be detache	by P	Part II. Other significant conditions co	ntributing to dea	ath but not resulting in the	a underlying c	ause given	in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
Vital Records,	w requires been sign should be		DEMONTIF	\					10	Yes 2 No	3 ☐ Prob	ably 4 □Unknown
000	s been s been s shoul	olete							24a. Was		Were auto	psy findings available
Re	The lav	Completed								rmed2	prior to cor death? 1 \(\text{Yes}	npletion of cause of
ita		0	25. Was case referred to medical				2	6. Place of Death				20.70
f V	di S	To B	examiner?	Hospital: 1 □ In	patient 2 ER/Outpa	tient 3 DC	Other:	4 Nursing Hor	me 5 Resid	dence 6 □Ot	her (Specif)	1)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b. Time , Day Year) Injur	of 2	8c. Injury at Work?	1	28d. Describe l	now injury occu	rred	
Sio	ttendil death. ctor: A y the fu	catio	2 ☐ Accident investigation			М		s 2 No				
Division	ira b	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Płace o building	of Injury - At home, farm, g, etc. <i>(Specify)</i>	street, factory	, office	1	28f. Location (5 City or Tov		ber or Rura	l Route Number,
	spitel or ours afte neral Dir filled in		00 0 0 0	<u> </u>								
	Hos 24 ho Fun	Medical	29a. Certifier 1 ✓ Certifying Phy (Check only 2 ☐ Medical Exam	iner: On the bas and manne	pest of my knowledge, de sis of examination and/or or stated	investigation	at the time, , in my opini	date and place, a ion, death occurre	and due to the ed at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s)
	To the Hospitel or within 24 hours at To the Funeral D completely filled in	Me	29b. Signature and title of certifier	and manifes		290	. License n	umber		29d. Date sign	ed (Month,	Day, Year)
	- 5 - 0		1 Ales in	D		1	7W >	aht		Apri	L 18	2005
	F		30. Name and address of person who o		of death (Item 23a) (Typ	e, Print)	1-1/	1.,7		1.0 0 -	10	2007
			HARIS ALG		1 75.5	016	u p	MIVE	TONS	W V	no	21204
	Sta		31. Date filed (Month, Day, Year)	32. Re	Ostrar's Signature	Anasti)					
	Regist	rar	APR 19	ZUUD 🔀	lesur st.	ASSESSED OF THE PARTY OF THE PA						

Erackson, Helen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Fordham Month **Physician** E, Henry, 2005 PM APri 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Mercy Medica Baltmare City If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County treumatic event, the Medical Examiner must be notified at MD BACTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23e 224 by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) mmed Forces! Mayes 2 ☐ No 1 Never Married 2 Married HACK 2 No 3 ☐ Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ring most of working s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DRRECTIONAL 17. Father's Name (First, Middle, Last, VICTORIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BATIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 4.20.05 OWINGSMILLS, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License VAUCHN C. GREENE FUNEXAL HIME 22. Name and Address of Facility auch BATIMIRE, MARY/AND 2/2/2 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Large Right Sided Intracranial Hemorrhage week /Medical Due to (or as a consequence of): Examiner 4 days Phen Aspiraha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Renal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? myelodysplasia 25. Was case referred to medical 25100 2 No 1 ☐ Yes 1 Yes aremial trambaglapenia 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

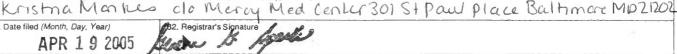
Division of Vital Records, P.O. Box 68760

Hospitel or Attending Physicien:

certificate be

31. Date filed (Month, Day, Year) APR 1 9 2005

29b. Signature and title of certifier



Manhes Medical Resident

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

P17658

29d. Date signed (Month, Day, Year)

APril 15 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 Joan D. Falker April 16 1:36 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Howard Columbia Howard County General Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 XF 085 46 4716 New York May 20, 1954 50 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Madical Examiner must be nutified at 1 Yes 2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21042 United States 10021 Carrigan Drive Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: Specify: þ White 3 Widowed 4 Divorced "naturel", Completed I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ith and Mental Hygiene. 27 is marked other then r traumatic event, it a Ma then Elementary/Secondary (0-12) College (1-4or 5+) Social Insurance Specialist Social Security Admin. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Maurer Joseph E. Falker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trat once. 10021 Carrigan Drive Ellicott City, MD 21042 Dorothy Falker/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Johns Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4-21-2005 Ellicott City, MD 21. Signature of Funeral Wice Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction few hours Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner vears Hypertension Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760, nding physicien Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No o 9 Unknown 9 Duknown signed by يم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Osteoarthritis 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 27 No 24a Was an certificate 1 ☐ Yes 2 🔯 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 🙀 No hours after death.
Ineral Director: After this
y filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L To the Hospital 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D30469 April 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N.B. Vellanki 9055 Chevrolet Drive #100 Ellicott City, MD 21042 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar APR 1 9 2005

Ethel M. Franz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Unpend Item 23a,27,28a-f per me G843 to Department of Health and Mental Hygiene Certificate of Death 05-2597 AKG 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician Ethel M. Franz P M 3. 2005 Apri1 1451 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner None University Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 3, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🟋 Yrs. 214 20 3531 80 Maryland Director Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or items 23a or 28e-f show 1 ☐ Yes 2 🛂 No Director MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4406 Dorado Drive 21043 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🕱 No Specify: Specify: 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental I marked Raymond Ellis Kathrine Hoetzel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 4406 Dorado Drive Ellicott City, MD 21043 Karen J. Ambrose/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Department of Importent: If it eny injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4-18-2005 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Colles 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple injuries with complications Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or 337,03 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 1 190 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ 2 □ No 24a. Was an 2 No Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 X Yes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 **X**No Pedestrian struck by suv investigation 2 Accident 4-2-05 noon after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State)4406 Dorado Drive in by determined 4 Homicide Driveway of residence Ellicott City, Maryland 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 To the complet 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 29c. License number OCME April 17, 2005 ss of pers n who complete 30. Name and ad cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #4c&10d PER FH &phy 8842 4/19/05 1. Decedent's Name (f 2. Date of Death 3. Time of Death Month Year **Physician** 2: Mam 0625 AM innegan 0011 121 <u>2005</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a BALTO COUNTY Augsburg Lutheran Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F 82 Director July 18 1922 MD 213-16-1223 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show itam 27 is markad other than "natural", or itams 23a or 28e-f shov other traumatic avant, the Medical Examinar must be notified at Yes ZYNo Directo Baltimore Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6811 Campfield Rd. 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. itam 27 is markad other than "natural", or Ital 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) communication n/a Machinist 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cecelia Weir James A. Finnegan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12214 Bonita Ave., Owings Mills, MD 21117 Penny Tognocchi/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ita 1 SyBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or once. Garrison Forest Vet. Cem.4/14/05 Garrison Forest,MD Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 21. Signature Lemmon owell M. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dementia Physician asculair /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent prechant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □ Yes 2 □ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably ◆ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be lirector, page 2 s 1 ☐ Yes 2 No 1 Yes Hospitel or Attanding Physician: : After this certific e funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; s after de-ral Director: After 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a ** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

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APR 1 9 2005

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2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🛭 🕦 5 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Richard Walter Franklin Sr. April 18 2005 1:15a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6520 Marvin Avenue Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 5 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1₩ 2□F 218-22-5198 Yrs. PA Director Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pagas 1 and 2 should ba filed within 72 hours after death with the Marylar nent of Health and Mental Hyglene.
ant: If item 27 is marked other then "natural; or items 23e or 28e-f ehow ant: If item 27 is the mean and the natural properties and item of the transities ovent, the Medical Examinat must be notified at Carroll Md Sykesville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6520 Marvin Avenue 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married WWTT Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No 3 ₩ Widowed 4 Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NCR Corporation field engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Franklin Vera Metcalf (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3394 Jeffrey Lori South, Finksburg, MD 21048 Mr. Richard W. Franklin, Jr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pagas I Department of H Important: If Ita any Injury or ot once. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 4/22/2005 Sykesville, MD 21. Signature of Funeral Service Licensee AATGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause in each Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, cause to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the use IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown signad b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 1 TYes 2 NO Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours a To tha Funaral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance (medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) tha 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) impleted cause of death (Item 23a) (Type, Print) Westmisster, MD 21157 exter 19 Registrar

State of Maryland / Department of Health and Mental Hygiene 13161

8	Physici /Medic Examin	an cal ier
	Funeral Director	
Frankenberger, Lathering Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner is use the reciliard at once.	To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 shoundary injury or other traumatic event, the Modical Examiner, ust by notified at once. To Be Completed by Funeral Director

Physician /Medical **Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certiticate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

1 - State Registrar	Cei	rtificate o	f Death		Reg. No.	.000	10101
1. Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death
Catherine Mary	Frankenber	rger		April	Day	2005	2:00am M
4a. Facility Name (If not institution, give street and number)		4b. City, Town	, or Location of De			County of Death	2.00dii
Greater Baltimore Medical	Center	Towson	1		Ra	1timore	
	e (In yrs. last birthday)	If Under 1 Ye	ar If Under 24 h		th	9. Birtho	place (State or Foreign
212-07-2307 1□ M 2 ਤਿ	93 Yrs.	Months Day	s Hours M	Feb. 2	ay, Year) 11 10 1	12 Mary	ntry) land
Usual Residence of Decedent				TED. Z	. 1 9 1 7 1	iz. mar y	Tana
10a. State 10b. County	10c. City, Town or Lo	cation				1	IOd. Inside City Limits
Maryland Baltimore	Glen Ar	^m					1 ☐ Yes 2 ☐ No
10e. Street and Number		10f. Zip Code)		10g. Citize	en of What Cour	ntry?
11630 Glen Arm Road		2105	7		U.S	S.A.	
11. Marital Status 12. Was Decedent		Was Decedent of	f Hispanic Origin?	? (Specify Yes or No		4. Race - Americ	can Indian,
Armed Forces? 1 Never Married 2 Married 1 Yes 2 If Yes, Give			uban, Mexican, Pu	uerto Rican, etc.)		Black, White,	
3 ☐ Widowed 4 ☐ Divorced If Yes, Give ↑ Year or Dates:		1□Yes 2风N	o Specify:		5	Specify:	hite
15. Decedent's Education	16a. Dece	dent's Usual Occ	upation		16b. Kind	d of Business/In	dustry
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4ors	life.	kind of work doi DO NOT use ret	ne during most of tred)	working			
12 vr's		Secretar	y		Unir	royal Ti	re Co.
17. Father's Name (First, Middle, Last)			18. Mother's i	Name (First, Middle			
	rankenberge			Anna		Baı	
19a. Informant's Name/Relationship (Type, Print) Melvin Frankenberger - Nep			et and Number or Street	<i>Rural Route Numb</i> Ocean Ci			
20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Date		ation - City or To	
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or other p	1	100 10005			
'4 □Donation 5 □ Other (Specify)		edeemer		/20/2005	Balt	timore,	MD
21. Signature of Funeral Service Licensee	1_ 22	2. Name and Add	Iress of Facility	Baltimore	e, Mar	ryland	21214
fant L dullah		eonard	J. Ruck,	Inc. 53	305 Ha	arford F	Rd.
23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not ent ne.	er the mode of d	ying, such as card	diac or respiratory a	rrest,		Approximate Interval Between
	OCARDII						Onset and Death
resulting in death)	a consequence of):	, —	'				12 11000
SE	PTICEN	117					24 hours
	a consequence of):					Ţ.:	2 1
causé. Enter Undertying Cause (Disease or injury that initiated events	INARY	TRA	J. T	NFEC	7101	2	3 days
	a consequence of):						
d. DIA	BETIC	KET	D Aci	21200			24hours
IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		7c			23	d. Date of delive	nry
in the past 12 months?]Ectopic pregnal] Other <i>(specify)</i>				Month	Day Year
9 ☐ Unknown							
Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use	e contribute to th	ne cause of death?
Dementia, A	CZHEIM	ER'S		10	Yes 2	Ño 3□Prob	ably 4 Unknown
LYDEDTEN	MOIZ			24a. Was	20	24h Mare aut	new findings available
L KELIEL	- 1017			_ auto	an psy prmed?	prior to cor death?	psy findings available appletion of cause of
				1 Ves	2 No		2 No
25. Was case referred to medical examiner?				Death (Check only o	one)		
1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie		IL 3 DOA	The second secon	g Home 5 🗌 Resi			1)
27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	28c. In W	ury at ork?	28d. Describe	how injury	occurred	
2 Accident investigation			□Yes 2□No				
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	eet, factory, offic	9	28f. Location (. City or Tox	Street and and wn, State)	Number or Rura	l Route Number,
29a. Certifier (Check only one) Certifying Physician: To the best Medical Examiner: On the basis of and manner street.	f examination and/or inv	occurred at the vestigation, in m	time, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s)
29b. Signature and title of certifier		29c. Lice	nse number		29d. Date	signed (Month, I	Day, Year)
PAMAN A	hop ALAN M	10 0	5/22	-8	41	17/2	001
30. Name and address of person who completed cause of		Print)	Vano I	FIET DA	المالية المراجعين		100000
ALMANA GODACAR MI	1 25 WL	MPh	VK157, 4	\$159 BA	UIM	IORE /	1) 21228
31. Date filed (Month, Day, Year) 32. Begistr	ar's Signature	and D					
AFR I 3 COUD Store	w so say						

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State

Registrar

			1 - For State Registrar	State of Maryland / Depa <i>Cer</i>	rtment of Health and Me <i>tificate of Death</i>	ental Hygien Rag. N	10105
	Physici	an	Decedent's Name (First, Middle, Last)	Helen Gabinet		2. Date of Death A Month	3. Time of Death
	/Medic Examir	al	4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death	Dril 1	4 2005 9:12AM
	CXAIIIII	lei	Levindale Nurs	ing Center	Baltimore		N/A
	Funeral Director		5. Social Security Number 201-16-8663 6. Sex 1□ N	7. Age (In yrs. last birthday) 7. 9 Yrs.	Months Dave Hours Min	B. Date of Birth (Month, Day, Year May 11,1	925 Pennsylvani
	ntand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
	ne Man Be-fsh diffed	ctor	MD N/	A Bai	ltimore		1 ☐ Yes 2 🕅 Mao
	th with the 23e or 2 and 15th contractions a	ai Dire	3710 Clipper Roa	ad	10f. Zip Code 2 1 2 1 1		S.A.
980	be filed within 72 hours after death with the Maryland that Hygiene. od other then "netural", or items 23e or 28e-f show event, I're Medicel Exato are rural to Indified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 📆 idowed 4 □ Divorced	1 🗆 V oo 2/05/400	Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race · American Indian, Black, White, etc. Specify: White
15-0	n 72 ho "netu	ietec	15. Decedent's Educat (Specify only highest grade c	tion 16a. Deced	ent's Usual Occupation kind of work done during most of working IO NOT use retired) Seanstress	16b. I	Kind of Business/Industry
212	filed withi Hygiene. ther then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) "/6. 2	Seanstress		London Fog
land	uld be filed fental Hygir rked other tic event, I	To Be (17. Father's Name (First, Middle, Last)	Harry Leon Cap	18. Mother's Name (Kathry	First, Middle, Maide yn Skapk	
Mary	ges 1 and 2 should be to of Health and Mental If item 27 Is marked or or other treumatic eve		19a. Informant's Name/Relationship (<i>Type</i> , Sylvia Barrett		Address (Street and Number or Rural look) Newport Avenue		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health s Importent: If item 27 It eny injury or other tre		20a. Method of Disposition 1 □ Burial 2 ☑ ☑ ☐ Gremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	noval from State 20b. Place of Disposementary, crem Balto/Wa	ition (Name of alory or other place) ash Crematory 4/	te 20c. l	Laure1, MD
Balti	permit. Departm Importe eny inju	1 1	21. Signature of Fureral pervice Alcensee	mounts Ho	Name and Address of Facility Burg	gee-Hens Falls R	s-Seitz Funeral oad Balto, MD
	Physician /Medical		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Cause on each line.	r the mode of dying, such as cardiac or	respiratory arrest,	21211 Approximate Interval Between Onset and Death
	Examiner petri	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
68760,	ificate be executed g physician and as the burial-transit	edicai Exa	resulting in death) Last	Due to (or as a consequence of):			
P.O. Box 68	ne death certif the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	w requires that the bean signed by should be detact	by	Part II. Other significant conditions contril	buting to death but not resulting in the un	derlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
Vital Records,	The ate h page	Completed				24a. Was an autopsy performed 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 20 No
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yo} \)	spital: 1 Phpatient 2 ER/Outpatient	26. Place of Death (6 ☐Other (Specify)
on of	Attending Phy r death. ector: After this by the funeral o	tion: T		28a. Date of Injury (Month, Day Year) 28b. Time of Injury		d. Describe how inju	
Division of	of attendate death after death Director: /	Certification;	2 Could not be	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28	f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai C	(Check only 2) Medical Examinar	ian: To the best of my knowledge, death r: On the basis of examination and/or inv and manney≪tated.	astination in my opinion, death occurred	at the time date an	of place, and due to the causo(c)
	To th withir To th comp	Me	29b. Signature and title of certifier	//	29c. License number	29d. Da	ate signed (Month, Day, Year)
,	n		icha Well	Allows of tests (New 2021)	D23767	Af	Pr. 114, 2005
			30. Name and address of person who comp Descript S WEP-TH 31. Date filed (Month, Day, Year)	JEINER IND 2	434 W. Belsed	ere Ave.	ate signed (Month, Day, Year) Pr. 114, Zeos Balto THZ1215
	Sta Registr		APR 1 9 2005	5 Row & Spi	ule		

				For State State Registrar	ate of Mar	yland / Dep <i>Ce</i>	artmen				giene () ()5	13163		
				Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death		
		Physici /Medio		Edythe Sophia Grego	ory					ACC:	Day 13	Zuls-	2215 M		
		Examir		4a. Facility Name (If not institution, give street			4b. City,	Town, or	Location of De	ath	4c. Count	of Death			
				St Agnes 1605 pita				lhn				N/A			
		Funeral Director		5. Social Security Number 6. Sex 1 □ M 2	77	In yrs. last birthday,	If Under Months	Days	If Under 24 H Hours Mi	n. (Month, Da	th 17, 1919	Coun	lace (State or Foreign try) ryland		
				Usual Residence of Decedent						Mar. 2	7, 1919	ria	Lyrand		
		rylan how		10a. State 10b. County	1	Oc. City, Town or L						11	0d. Inside City Limits		
		death with the Maryland ms 23a or 28a-f ehow rmst be notified at	Director	MD N/A			Bal	Ltimo	re				1X Yes 2 No		
		with the	Dire	10e. Street and Number			10f. Zip		01000		10g. Citizen of				
		eath is 23,	eral	3200 Clarinda Avenue	as Decedent Eve	orin IIS 12	Was Door		21230	(Coordy Von or No		ed St			
	(0	r iten	Funeral	1 Never Married 2 Married 1	med Forces?				, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ck, White,	etc.		
	03	rai', o	by	3 ☐ Widowed 4 ☐ Divorced If	Yes, Give ear or Dates:		1 ☐ Yes 2	2 ∭ No	Specify:		Specif	y:Whit	e		
	5-0	72 h natu	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Dece (Give	dent's Usua kind of wor	il Occupat rk done di	tion uring most of w	vorking	16b. Kind of B	usiness/Inc	dustry		
	121	within	mp	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	lite.		se retired) emake				Own	Yome.		
	d 2	Hygir Hygir Sther		17. Father's Name (First, Middle, Last)			1101110			ame (First, Middle,	, Maiden Sumar		Home		
	Maryland 21215-0036	lid be lental rked o	To Be	William Miller					I	Katherine	Belchn	er			
	ary	and N		19a. Informant's Name/Relationship (Type, Pr	int)	19b. Maili	ng Address	(Street ar	nd Number or	Rural Route Numbe	er, City or Town	State, Zip	Code)		
	Σ,	and 2 ealth n 27 i		P. Rowland Gregory	Husband	A STATE OF THE PARTY OF THE PAR			Ave.,	Baltimor	e, MD 2	1230			
	ore	ges 1 t of H if ites or oth		20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ Remov		20b. Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther place)	Date	20c. Location	City or To	wn, State		
	Loudon Park Cemetery 4-18-2005 Baltimore														
	Bal	permi Depar impo eny ir		22. Name and Address of Facility Ambrose Funeral Home, Inc.											
				23a. Part1. Enter the disease, or complication	s that caused the							, MID	21227 Approximate		
		Enysician		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death disease or condition Shock Triangle Cause (Final disease or condition)											
		/Medical		resulting in death)	Due to (or as a c	-							17. heurs		
	Ы	Examiner		Sequentially list conditions b.		Sipsis							Helhours		
		be is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):									
	_	and and II-tran	Examiner	that initiated events	Due to (or as a c	consequence of):						-			
	8760,	icate be executed physician and s the burial-transit			(
73	89	ifficate g phy as the	edlo	0											
72	ŏ	th cert endin r use	M/us	230. Was decedent program 47	/es, outcome of ¡ □Live birth 2 [□Ectopic pre	ecnancy				te of delive	•		
1.7	Э. В	e deal he att	Physician/Medical	1 Yes 2 No	Pregnant at tim		Other (spe				Mo	enth	Day Year		
)	P.0	d by t		9 ☐ Unknown Part II. Other significant conditions contributions	ng to death but r	not reculting in the u	ndorh ing o	NIA AWAR	n in Port I	22a Did t	abaasa usa sasi	ributo to th	e cause of death?		
3	ds,	The law requires that the death certifi te has been signed by the attending I age 2 should be detached for use as	d by	Chrine Obo	1 1 .	Pulmin	The state of	5 6 5 6			Yes 2□No	3 □ P obs			
3	Recor	w req	ompleted)			24a. Was	an 24b.	Were auton	sy findings available		
5		icien: The lav certificate has rector, page 2	omp							autop perfo	rmed/	prior to com death? 1 Yes	osy findings available inpletion of cause of		
$\overline{}$	ita		Be C	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only o		1 1 1 1 1 1 1	2 140		
		Physicien: r this certificaral director,	To E	examiner? 1 ☐ Yes 2 ☐ No Hospita	II: 1 Inpatient	2 ER/Outpatier	nt 3□ DO	A Other	4 Nursing	Home 5 Resid	dence 6 □Oth	er (Specify)		
	טע	ding P	on;	27. Manner of Death 28a 1 ☐ Natural 5 ☐ Pending	. Date of Injury (Month, Day Y	(ear) 28b. Time o		Bc. Injury : Work?		28d. Describe h	now injury occur	red			
	Division of Vital	ttend death stor: /	ertiflcation;	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury	At home form at	M		es 2 □No	204 Legation (6	Ctront and Missa		Davida Mora ha		
	Diγ	after after Direct	ertif	4 Homicide determined	building, etc. (- At home, farm, sti Specily)	eet, ractory,	OHICE		City or Tox	Street and Numb vn, State)	er or murar	noute Number,		
		spite hours ineral y tilled	aC	29a. Certifier 1 Certifying Physicien	To the best of n	ny knowledge, deat	h occurred a	at the time	, date and pla	ce, and due to the	cause(s) and ma	inner as sta	ated.		
		To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely tilled in by the fune.	edical	(Check only 2 Medical Examiner: 0	n the basis of ex and manner stated	ramination and/or in	vestigation,	in my opi	nion, death oc	curred at the time,	date and place,	and due to	the cause(s)		
		To t To t	Σ	29b. Signature and title of certifier			29c.	License	number 43952		29d. Date signe	d (Month, E	Day, Year)		
				" ('Alla)	Do			1170	1703 00		Mark	15			
	1	2 1			C. ILLia	th (Item 23a) (Type,	Print) Ag	r25	Hospitz	1 400	Coten P	ne.	Beltmine		
		Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2005	32. Registrar's	Signature									
						23 600	200								

			1 - For State Registrar	State of	Marylan		artment			and Me	ental Hy	giene Reg. No.	005	yesteen S	1164
	Physici /Medi	cal	Decedent's Name (First, Middle, Terralea G. Greef 4a. Facility Name (If not institution,	f	nar)		4b. City, 1	Fown or I	ocation	í	2. Date of De Month	Day	Yes	o5 0	me of Death
	Examir	ner	Union Memorial Hosp	ital			Balt	imore				N/	Ά		
Ŀ	Funeral Director		5. Social Security Number 233-42-2140 Usual Residence of Decedent	6. Sex 7. 1 □ M 2 □ F	Age (In yrs.	Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Bi (Month, Di NOVEMBE)	17, 1	.929 V	Birthplace (S Country) VEST Vir	ginia
	Maryland	tor	10a. State 10b. County Maryland Baltimo	re	_	y, Town or Lo WSON	cation								ide City Limits Yes 2 No
	th with the 23a or 28 at be not	al Director	10e. Street and Number 204 East Joppa Road	Apt. 413			10f. Zip	Code 21286				10g. Citize	on of Whal	Country?	
9036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-f show to Madical Everifier must be notified	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceded Armed Force of 1 Test 2 If Yes, Give Year or Date	es? No	'	Was Decede f Yes, speci		panic Orig , Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No ican, etc.)		Race - A Black, W		an,
Maryland 21215-0036		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)	completed) (Ĝive life. E			Jent's Usual Occupation kind of work done during most of working OO NOT use retired) Tephone Operator			7	16b. Kind of Business/Industry Signet Bank			
/land	should be filed ind Mental Hygid marked other umetic event, II	To Be (17. Father's Name (First, Middle, L Frank Abrams	ast)						rs Name (na Smit	First, Middle h	, Maiden Si	umame)		
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other treumetic		19a. Informant's Name/Relationshi Ferdinand Greeff/So								Route Numb	er, City or 1 21093	own, State	e, Zip Code)	
Baltimore,	Pages 1 ment of He ent: If iten lury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (Sp.	ecify) Entombmen	t Park	lace of Dispo emetery, cren KWOOd Ce	meterv			Da 4/21/0				or Town, Sta	
Ball	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Service Li	L'Hutte	on	5		rtora	Koad	Balti	more Ma	ryland			100
V	Cate be executed hysician and physician and the burial-transit sthe burial-transit	Examiner	23a. Part1. Enter the disease, or control shock, or heart failure. List of immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a	n line.	uence of):	r	*		cardiac or	respiratory a	rrest,		Approxinterva Onset	imate al Between and Death
P.O. Box 68760,	that the death certificate bed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		t at time of de	death 3	Ectopic pre Other (spe					230	d. Date of o	delivery Day	Year
Ś	w requires that been signed k should be deta	by	Part II. Other significant condition	s contributing to deat	h but not resu	ulting in the un	derlying car	use given	in Part I.					to the cause	e of death?
al Reco	s b	Completed								_	24a. Was autop perfo 1 Yes	rmed?	24b. Were prior to death	o completion	
Division of Vital Record	To the Hospitel or Attending Physicien: The Is within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page:	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investiga	Hospital: 1 Inp 28a. Date of 1 (Month,	ER/Outpatient 28b. Time of Injury		Other: c. Injury a Work?	4 □ Nur	sing Home	Check on d 5 ☐ Resid d. Describe I	dence 6		pecify)		
/Divis	tel or Atters after de si Directo	Certification:	3 Suicide 6 Could no determin	ed 286. Place of	Injury - At hosetc. (Specify	me, farm, stre	et, factory,	office		28	f. Location (S City or Tov	Street and N vn. State)	lumber or	Rural Route	Number,
	the Hospitel or Attending hin 24 hours after death. the Funerel Director: After mpletely filled in by the fune	edical	one)	Physician: To the be teminer: On the basis and manner	s of examinat	wledge, death ion and/or inv	occurred at estigation, i	the time, n my opin	, date and nion, death	place, and occurred	d due to the at the time,	cause(s) an date and pla	d manner ace, and d	as stated, ue to the cau	ISO(S)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier Tocclyne 30. Name and address of person w JOCCLYNE KOUTTE	eou etch	וטטו	MD	29c.	License r	3 2	146	2	29d. Date s	igned (Mo	onth, Day, Yes	ar)
	6		30. Name and address of person will jocclyne koutric						Kive	13 1	sait;	mure	2 17	216	212
	Sta Registr	te ar	31. Date filed (Month) (ear)	2005	strar's Signat	ure	made)								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Nancy Jean Gore 0943 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BAITIMORE
If Under 1 Year If Under 24 Hrs.

Hours Min. N/A Hanes Healthcare 8. Date of Birth Sept. 23,1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 XF 212 32 8590 71 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 ☑ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 456 Caledonia Avenue 21227 .S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (not available) Zeurlaut Dorothy E. Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Gore / son 456 Caledonia Avenue Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4/15/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. granusau 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adherosclerot Immediate Cause (Final il Cordiovasculor Milecise 20 years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show

"neturel", or Items 23e or

the Medical

27 is markad othar then treumatic svent, the Me

or other tre

Department of Important: If any injury or once.

Direct

Completed by Funeral

Be

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Examiner

Physiclan/Medical

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Completed

Certification:

Medical

the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

Records,

Vital

Division of

Hospital or Attending

within 24 hours a

completely

the death certificate be

as the burial-transit physician attending p for use as ed by the a detached f signed b page 2 should peen has certificate funeral director. this after death.

Director: Af filled in by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No

3 ☐ Probably 4 ☐Unknown

24a. Was an autopsy perform rmea? 2021 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
APR 1 9 2005 ryden 2. Registra s Sign

State Registrar

			For State Registrer	State	of Maryla		artment <i>rtificate</i>		ealth and M eath		giene Reg. No.	05	13166	
			Decedent's Name (First, Middle	e, Last)						2. Date of De	ath		3. Time of Death	
	Physici /Medio		Theodore Glov	vacki, II	I					Month April	15,	Year 2005	9:50 A M	
	Examir		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, T	own, or Lo	ocation of Death			inty of Death		
			16609 Roundal	out Driv	e		Gai	thers	sburg		Mo	ntgome	erv	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs 54	. last birthday)	If Under 1	Year I	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		place (State or Foreign	
L	Director		220-50-5693	1 ☑ M 2□F	180 M 2□F 34 Yrs.					May 24,	1950		yland	
	and		Usual Residence of Decedent 10a. State 10b. County	-	10c. C	ity, Town or Lo	ocation					T.	10d. Inside City Limits	
	Maryl f sho	ō		gomery		aither							1 ☐ Yes 2X No	
	28e-	Director	10e. Street and Number			- CHCI	10f. Zip C	ode		- T	10g. Citizen	of What Cour		
	3e or	ā	16609 Roundabou	t Drive				0878					•	
	ms 2	Funeral	11. Marital Status	12. Was De	cedent Ever in I	J.S. 13.	Was Decede	nt of Hisp	panic Origin? (Spe	ecify Yes or No		ed Sta		
9	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show disal Ever ill writhust be recitified at	Fur	1 ☐ Never Married 2 🛚 Marr	ied 1XX Yes	2 □ No		If Yes, specif	y Cuban,	Mexican, Puerto	Rican, etc.)		Black, White,	etc.	
03	rel', o	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	live 1971 Dates:	1 <u>-</u> 1972	1 □ Yes 21	ΔINo .	Specify:		Spe	city: W	hite	
5	72 h	Completed	15. Deceden (Specify only highe			16a. Dece	dent's Usual	Occupation	on ring most of worki	ina	16b. Kind of	Business/In	dustry	
2	vithin ne. hen '	mpl	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use	retired)	-					
7	led w lygier her ti	ပ္ပ	17 Fabrus Name (Fine Addul	2		Hardy	ware/Pa		Special:			Retail	<u></u>	
anc	l be findal hed of	Be	17. Father's Name (First, Middle,						8. Mother's Name			name)		
Maryland 21215-0036	d Mei nark netic	2	Theodore Glowa 19a. Informant's Name/Relations			405 14-70			LaGretta					
<u>⊠</u>	d 2 s th an 7 is r treur		Thelma Glowack						d Number or Rura					
	s 1 and 2. If Health ar item 27 is other treu		20a. Method of Disposition	T/MTI6	20b.	Place of Dispo	KOUNG	abou		Gaithe		, Mary . n - City or To	land 20878	
nor	ages nt of t: If it		1 X Burial 2 ☐ Cremation		_ 1	cemetery, crer Parl Memoria	natory or oth	ar olaca) -	Apr	il 20.			Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Ever it with nast ke ricitized an once.		* 4 □ Donation 5 □ Other (S		1					005		•	-	
Ba	permi Depar Impo any ir		► Haura	Jaws	M01420	$0 \qquad \begin{vmatrix} \vec{R}_i \\ \vec{3} \end{vmatrix}$	obert A 00 West	Pum Monte	of Facility phrey Fund comery Ave	eral Home	·/Rockvi	lle, In Marylar	c. nd 20850-2805	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately 124 and 125 are 125 ar											
	Pnysician ·		Immediate Cause (Final disease or condition		izure								Interval Between Onset and Death	
	/Medical		resulting in death)	a	(or as a conse	quence of):						1		
	Examiner		Sequentially list conditions	S1e	eep Apne	ea								
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):								
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	U	esity									
60,	be ex cian a	E)	rooming in doubly East	Due to	(or as a conse	quence of):								
68760,	ficate be executed physician and s the burial-transit	edlcal		d										
_		/Me	IF FEMALE:	23c If was ou	utcome of pregn	2004								
Вох	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	birth 2 □Fet binant at time of	aldeath 3□	Ectopic preg					Date of delive Month	ery Day Year	
<u>Р</u> О	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr		death 5∟	Other (spec	пу)					,	
	The law requires that the death certifule has been signed by the attending age 2 should be detached for use a	/ Ph	Part II. Other significant condition	ns contributing to	death but not re	sulting in the ur	nderlying cau	se given i	in Part I.	23e. Did to	bacco use co	ontribute to th	e cause of death?	
Vital Records,	uires sigr	d by								1 🗆 Y	es 211 No	3 Prob	ably 4 Unknown	
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Re	he lav e has age 2	Completed								autop	sy med?	prior to cor death?	npletion of cause of	
ā		e C	25. Was case referred to medical					0.6	C Diago of Dooth	1 Yes		1 🗌 Yes	2□ No	
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Division of	된 두 등		27. Manner of Death	28a. Date	of Injury ofth, Day Year)	28b. Time of		Injury at Work?	4 L IAdising Hon	8d. Describe h			//	
0	nding lath. r: After	atio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig	9	ntn, Day Year)	Injury	М		s 2 □ No					
N S	or Atten after deat Director: in by the	tific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Place	e of Injury - At h ling, etc. (Speci	ome, farm, stre	eet, factory, c	ffice	2			nber or Rura	l Route Number,	
	tel or A s after el Dire ed in by	Certification:		build	iing, etc. (<i>apeci</i>	19)				City or Tow	n, State)			
	To the Hospitel or A within 24 hours after To the Funerel Director Completely filled in by	edical	29a. Certifier 1 (Check only one) (Check only one)	g Physicien: To the Exeminer: On the b	pasis of examina	owledge, death ation and/or inv	occurred at restigation, in	the time, my opinio	date and place, a on, death occurre	and due to the ded at the time, o	ause(s) and r late and place	manner as st e, and due to	ated. the cause(s)	
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	1		30. Name and address of person			m 93a) /T 1	Print)				_	-		
36	11.		James Michael An					oad.	Suite 21	OD. Gai	thersh	urg. M	D 20877	
	Sta		31. Date filed (Month Cay, Year)						2-200 21		JC	69 11		
	Registra	ar	APK T 9	ZUUD	Registrar's Sign	U 199								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Mary Platenyk Gensior 2005 April 13, 4:16 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery | H Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Min. | March 21, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F 80 Yrs. Director 092-20-3101 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event, the Madical Examinant, ust be notified at Directo Maryland Montgomery 1 ☐ Yes 2 ☑ No Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13008 Scarlet Oak Drive 20878 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within hand Mental Hygiene.
7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Platenyk Katerina Ivanescue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m eny injury or other treum John Gensior/ Husband 13008 Scarlet Oak Drive, Darnestown, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Darnestown Presbyterian April 16, 1 ₺ Burial 2 Cremation 3 Removal from State Gaithersburg, * 4 □ Donation 5 □ Other (Specify) 2005 Church Cemetery Maryland 21. Signature of Funeral Sen 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00689 Enter the disease, or complications that caused the decided allure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Oronar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events an cresti Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Mo
9 Unknown 23d. Date of delivery atten for u 3 □Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been si 1 ☐ Yes 2 Mo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 202No 1 ☐ Yes 2 RONo 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 Who 1 Impatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Ceath 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifiet Medical 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who cor eted cause of death (Item 23a) (Type, Print) 13219 Executive Park Terrace, Germantown, MD 20874 Sayed Elsayyad, M.D., 31. Date filed (Month, Day, Year) 32 egistrar's Signature State APR 1 9 2005 Registrar

			1 - For State Registrar	State	of Ma	aryland /	Depa <i>Cer</i>	ırtment <i>tificate</i>	of He of D	ealth and M <i>eath</i>		gierje Reg. No.	005)	13168
	Physici		1. Decedent's Name (First, Midd Mary Elizabet		:						2. Date of Dea	ıth)5 Ye	ar	3. Time of Death 3:53 p м
	/Medic Examir		4a. Facility Name (If not institution	on, give street and	number)			4b. City, To	own, or L	ocation of Death		4c. 0	County of D	Death	
	Funeral Director		30240ak Green 5. Social Security Number 234-09-4017	Court 6. Sex 1□M 2∏F		e (In yrs. last b	irthday) Yrs.	Ellic If Under 1 Months		City If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day	Year 9	Howa 9.		ace (State or Foreign ry) WV
	put &		Usual Residence of Decedent 10a. State 10b. Count			10c. City, Tov		nation .			1				
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	with the 3a or 28a	I Director	10e. Street and Number 3024 Oak Greet	n Court				10f. Zip C	2104	·3		_	en of What	t Count	ry?
980	be filed within 72 hours after death with the Maryland ital Hygiene. bd other then "neturel", or Items 23a or 28a-f show event, tre Madical Examination matter natified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed	rried 1 TYe	ecedent I Forces? s 251 Give r Dates:	Ever in U.S.		Vas Deceder Yes, specif		panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
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Maryland 21215-0036	be filed within tal Hygiene. d other then '	Be Co	17. Father's Name (First, Middle								ne (First, Middle, Maiden Sumame)				
ylai	2 should be and Mental Is marked of eumetic ev	To	John Thomas								ary Char				
<u>a</u>	nd 2 st lith and 27 Is m	1	19a. Informant's Name/Relationship (Type, Print) Janice Elward 11655 Gilman Lane, Herdon, VA 20170 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State												Code)
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Balti	permit. I Departm Importer eny inju		21. Signary Funeral Service Lio 68 22. Name and Address of Facility Fink Funeral Home P A												
	*		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and interval Between Interval Between												1961 Interval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	les	4 1/8	en	Hu	er.	houp	CHEN				Onset and Death
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	be sit	iner	Sequentially list conditions, 1 any, washing to immadate cause. Enter Underlying Cause (Disease or injury that initiated events c. M. A. M. C.												
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	를 구 등	2	1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatier		_			4 Nursing Hor				Specify)	
on	Attending Physicien: r death. sctor; After this certifici	atlon	1 ☐Natural 5 ☐ Pendi	ng (Mi	te of Injur onth, Day	Year) 280.	Time of injury	28C	o. Injury at Work? 1 ☐ Yes	s 2 \square No	28d. Describe h	w injury	occurred		
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	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To t Examiner: On the	he best o basis of anner stat	examination an	e, death	occurred at estigation, in	the time, n my opini	date and place, a ion, death occurre	and due to the cased at the time, d	ause(s) ar ate and p	nd manner lace, and c	r as star due to t	ted. he cause(s)
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	(10)		30 Name and address of person 31. Date filed (Month, Day, Year,	PIKAC	rul	45 -	ber	hor!	4.	rote 100	0 050	nor	lhu	1	2124
	Sta Registr		APR 1 9		negistra	r's Signature	Soo	de							

ELIZABETH HARBERT

State of Maryland / Department of Health and Mental Hygiefie For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:30 P M **Physician** 3_ 2005 April Thomas Hall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Laurel Prince Georges Laurel Regional Hospital 8. Date of Birth (Month, Day, Year) May 14,1922 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Hours 1₺M 2□F Yrs. 258-16-0436 82 Wash.GA Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic svent, the Medical Examiner must be notified at *☐Yes 2☐No MD Prince Georges Hyattsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 6000 Sargeant Rd #208 20782 U.S.A. Items 23e Completed by Funeral death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mential Hygiene. If item 27 is marked other than "netural", or Item any injury or other traumatic svent, Ital Medical Examinations. 1 BYes 2 No If Yes, Give Year or Dates: 42to45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Painter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willis William Hall Beatrice 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6000 Sargeant Rd.#208 Hyattsville,MD.20782 Wife Betty H.Hall 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕏 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Olivet Cem. Apr.8,05 Washington,D.C. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licensee Trances 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Pnysician /Medical Due to (or as a consequence of) **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Aspiration Pneumonia Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Congestive Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmonary Disease 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🕇 No 2 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \) 24 hours a t 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 April 5, 2005 D45217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adebowale Ajayl, M.D. 6201 Greenbelt Rd. #415 College Park, MD. 20740 Registr s Signature 31. Date filed (Month, Day, Year State 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - State Registrar Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Funeral 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 378 Min 2 🗆 F Hours Director Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Trined Fo 1 Never Married 2 Married 2 No 9 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medic 2005. (Specify only highest grade completed) dary (0-12) College (1-4or 5+) OWARD, DAVID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Jelson HOWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b Place of Disposition (Name of company crematory crematory criother place) YOHLE . Method of Disposition Burial 2 Cremation 3 F 3 Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Diseas or in jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 DiNo certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 XNo Other this 4 ☐ Nursing Home 5 ☐ Residence 6 No ther (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury ccurred After Natural 2 Accident 5 Pending Director: / investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

To the I the

0

Registrar

(Check only one)

29b. Signalure and title of certifier

ES

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) hances ST BATTIMORE 6601 NC Registrar's Signature

D58303

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 22 per fh 9842 4-19-05 vt. State of Maryland? Department of Health and Mental Hygier 0 0 5

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Healey Month 1 Day Year 13 23 PM Vanela 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Baltimore 114 Hopkins The Johns 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 55 Months Days Hours 1 □ M 2 □ X 215-58-2471 Yrs. Director 10/15/49 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 28a-f ahow 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD Director Baltimore, MD 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a or 6512 Hartwait Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: þ 3 Widowed 4 Morced Specify: White "natural", dical Exa Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. The Mon Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Own Home it of Health and Mental Hygis If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Ferdinand Hasselberger ဂ္ <u>Ruby Clarke</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Bandjough - friend 6512 Hartwait Street, Balto., MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State intment cortant: 1 * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4/20/05 Baltimore permit.
Departn
Imports
any nju 21. Signature of Funeral Service License 22. Name and Address of Astiton Bradley Ashtron Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

2134 Willow Spring Rd shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 10 days /Medical Due to (or as consequence of): Examiner Due to (or as a consequence o): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Chronic Obstrictive Pulmonare Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) detached Division of Vital Records, P.O. the 9 Unknown 9 Unknown þ signed Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. filled in by the fu 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 16, 2005 RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Hopkins Hospital 600 North Wolf Street Baltomore Manyland Dr. Emily Sydnor 21287 32. Restrar's Signature 31. Date filed (Month State Registrar

ase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #2911, perMD, (351, 1723/06 TI State of Maryland / Department of Health and Mental Hygiene Amend item #23PII Per PHY 685 Fige 1800 OF SHIP Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 3:16A HOM 17 2005 /Medical 4c, County of Death ocation of Death 4a. Facility Name (If not institution, give street and number) Examiner JLEN BURNIE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. Year 1**∑**M 2□F 217-50-9574 Yrs MD 57 **Director** 9-11-1947 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits If item 27 is marked other than "neturel", or items 23e or 28e-1 show or other treumatic event, the Mactical Examinar must be notified at 1 ☐ Yes 2 ☐ No MD Anne Arundel Directo Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Linda Lane 21108 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Insurance Underwriter Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Edward Spring Hatch Nan Edith Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other treu once. Mrs. Sondra Jaye Hatch / wife 50 Linda Lane, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 4/20/05 1 ☑ Burial 2 ☐ Cremation Removal from State Baldwin Memorial Millersville, MD Donation 5 Other (Specify 21. Signature of Fun ral Service License 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LIENT CHEVASIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner alcohol USA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last be exec Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Depression 1 ☐ Yes 2 ☐ No 1□ Yes 22 No Post-traumatic Stress Disorder Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28a. Onte of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onal 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie MD 301 HOSPI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend item 1 per phys 3842 4-19-05 vt.

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

		Certificate of Death	Reg. N	2005 13173
	Physician	1. Decedent's Name (First, Middle, Last) / Julia Cornelia Hundley	2. Dete of Death	ay Year 3. Time of Death
Warter Co	/Medical	Julia Hundley	HPMI /	3 2005 1.18 pm
_)	Examiner	4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or	Location of Deeth 4	c. County of Death
	*	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8 Date of Birth	O Pirthologo (State or Foreign
	Funeral Director	224-05-0527 1□ M 2√2 F 94 Yrs. Months Days Hours Min	. (Month, Day, Year	9. Birthplace (State or Foreign Country) 1910 Virginia
	pue *	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	f she	Maryland Harford Abingdon		1 ☐ Yes 2½ No
	rec	10e. Street end Number 10f. Zip Code	10g. C	ifizen of What Country?
	23a o Est be	20 Box Hill South Parkway 21009		USA
Baltimore, Maryland 21215-0020	filed within 72 hours after death with the Meryland Hygiene. ther than "natural", or items 23s or 28s-f show out, the Medical Examinar must be natified at examinar must be natified at examinar must be natified at examinar must be natified at examinar must be natified at examinar must be natified at examinar must be natified at examinar must be not set of the property of the prope	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes ② □ No If Yes, specify Cuban, Mexican, Puer If Yes, Specify: 1 □ Yes ③ □ No If Yes, Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
20	72 ho	15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of wo	16b. I	Kind of Business/Industry
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2	be filed within ital Hygiene. d other than event, the Me	8 Bindery Worker		rinting
anc	Baby W		me (First, Middle, Maide	n Surname)
Ž	should be and Mental marked o umatic eve		ice Mahone	
Ma	47 th 8 14 th	19a. Informant's Name/Relationship (Type, Print) Clarence Hundley/Son 19b. Mailing Address (Street and Number or R 3424 Widow's Care, Fa		21047
ē,	- 7 E E	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. L	ocation - City or Town, State
Ĕ	permit. Peges Department of h important: if its any injury or of	1 Removal from State 4 □ Donation 5 □ Other (Specify) Highview Mem. Gardens	4-16-05 Fal	lston, MD
att	mit. partn ports y inju	21. Signature of Funeral Service Licensee 22. Name and Address of Facility McContas Funeral Ho	mo D 7	
a	82 = 8	Steples a Much 1317 Cokesbury Ros		. MD 21009
		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.		Approximate Interval Between
d.	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) a. <u>CHRONIC OBSTRUCTIVE LUNG</u> Due to (or as a consequence of):	DISEASE	Onset and Death
ox 68760,	seth certificate be executed ettending physician and for use as the burial-transit claryMedIcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
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0	net the deeth or d by the ettend letached for us Physician/	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacc	o use contribute to the cause of death? 2 No 3 2 Probably 4 Unknown
S, G		HYPERTENSION, ATRIAL FIBRILLATION,	I La res	EL NO SIALFICORDIY 4 DOINGOVII
Vital Records,	The law requires that the death cate has been signed by the ette page 2 should be detached for Completed by Physicia	CONGESTIVE HEART FAILURE	24a. Was en euto performed?	opsy 24b. Were autopsy findings available prior to completion of cause of death?
=	ysician: The law is certificate has b director, page 2 sl		1 ☐ Yes 2	No 1 □ Yes 2 □ No
ij	certificate rector, pag	exeminer:	ath (Check only one)	
ō	Attending Physician: ordeath. octor: After this certific by the funeral director, Ification: To Be (27. Menner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28c. Injury at Work?	fome 5 ☐ Residence 28d. Describe how inju	
ź	tai or Attending P rs efter death. el Director; After t led in by the funer. Certification:	Accident investigation 3 Suicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, le)
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et al. (Check only one)	e, and due to the cause(s urred at the time, date an	.) and manner as stated. d place, and due to the cause(s)
	Vithir comp	29b. Signature and title of certifier 29c. License number		ate signed (Month, Day, Year)
		Midliayken MD 745344	04	114/2.005
	11	30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)		111000
	7	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SURTSH DHANDANI AD 622 S. UNION AVE HAVIRE DE 31. Date filed (Month, Dev. Year). 32. Digistrer's Signature	GRACE, M	0 21078
	State Registrar	31. Date filed (Month, Dey, Year). APR 1 9 2005	,	

amend if the Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year HELLMAN APRIL 2005 16 /Medical 12:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4312 OLD COURT ROAD APT. 2-B BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10/16/1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months 577-05-7901 Yrs 91 Director NY Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23e or 28a-f show inversity the notified at 1 ☐ Yes 2 ☑ No Funeral Director MD BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e or 4312 OLD COURT ROAD APT. 2-B 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Be Completed by the Medical Exam 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ BENJAMIN EISEN VICTORIA HINDUSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Arthurss (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 IĎYWOOD ROAD BALTIMORE, MD 21208 LORNA KANE / DAUGHTER other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6 permit. Page Department of Importent: If any injury or once. '4 □ Donation 5 □ Other (Specify)

21. Signature Funeral Service Pens BALTIMORE HEBREW 04/18/2005 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us contribute to the cause of death? 1 ☐ Yes 3 Probably 4 Unknown Completed No 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 22 No 1 Yes 1 Yes or Attending Physicien: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check o Hospital: Other: 4 Nursing Home Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □ Other (Specify) in by the funeral 28c. Injury at Work? 27. Manni of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation atural Injury death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Coul not be del mined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar HOUN

completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month

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			For State Registrar	State of I	Maryland	-	artment tificate					Reg. No.	005	131	175
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	/Medic		4a. Facility Name (If not institution, g		9r)		4b. City,	Town, or	Location	of Death	·	4c.	County of Dea	th	
	Exami	ŭ	Mercy Hosp				Bal		-	4	ty				
	Funeral Director		218-44-8204	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. Ia 61	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Do 01-05-1	Day, Year) Country)			
	lend ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside (City Limits
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	≨ 9 €	Dire	10e. Street and Number				10f. Zip					10g. Citiz	en of What Co	ountry?	
٠	eeth w	eral	1208 N. Caroline Str	eet 12. Was Decede	nt Ever in U.S.	13 \		21213	snanic Ori	igin? (Spe	cify Yes or N	o- 1	USA 4. Race - Ame	nican Indian,	
36	within 72 hours efter de sne. then "naturel", or item 'e Medical Exentrel	by Funeral Director	11. Marital Status 1. Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	s? ∑No	(fYes, spec		Specity:		ecify Yes or No Rican, etc.)		Black, Whit		
9-9	2 hou	ted	15. Decedent's	Education		16a. Deced	ient's Usua kind of wor	I Occupa	ition	t of worki	na	16b. Kir	d of Business		
21215-0036	ofthin 7	Completed	(Specify only highest : Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us Labo	e retired,)	I OF WORK	ng .		Constru	ction	
d 21	be filed wit tal Hygien d other the	S C G	17. Father's Name (First, Middle, La	st)			Lab	Ter	18. Mothe	er's Name	(First, Middle	, Maiden			
'lan	Mental Mental arked c	To Be	Kenneth Jones						Sall	ie Fov	wkles Jo	nes			
Maryland	and and		19a. Informant's Name/Relationship				•						Town, State, a	Zip Code)	
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ğ	Pages ent of I nt: If it		1 Burial 2 Cremation 3 '4 Donation 5 Other (Spe		ILO I	metery, crer Zion Cer		ther place		4-15-(05	Lans	downe, M	D	
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Lie		, 110	22	. Name an		s of Facili	ty					
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3760,	Physicien but but is in a principle.	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a conseque as a conseque as a conseque	ence of):	fire	yt - 70	hmi	ina	1		15	MINU	
P.O. Box 68	law requires that the death certifics es been signed by the ettending pt . 2 should be deteched for use es it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								2	23d. Date of delivery Month Day Year		
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of V	Physic this ce al dire	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital:		R/Outpatier 28b. Time of			4 🗆 NI		me 5 ☐ Res 28d. Describe		Other (Spe	cify)	
O	ing After	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of I (Month,	Day Year)	Injury	м	8c. Injury Work	:?ີ່ ∕es 2. 🗆		Lou. Describe	now anjury	Cocarroa		
Division	il or Attendi efter death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could no determin	be 28e. Place of	Injury - At hon , etc. (Specify)	ne, farm, str	eet, factory	, office				(Street and wn, State)	Number or R	ural Route Nu	mber,
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: / completely filled in by the f	Medical C		Physician: To the be aminer: On the basi and manner	s of examination										(s)
		Me	29b. Signature and title of certifier	M	of death (Item:		P 290	i. License	number			29d. Date APRII	signed (Mont	th, Day, Year)	
	2		30. Name and address of person w	no completed cause	of death (Item	23a) (Type,	Print)	P	1010	Co	Bol+:		Manda	d 21	202
			MARK IGUCHI /	1.D. Mercy	HOSPITE	ure 50	1 37.	Falu	1 Pies	4,	MILIM	16,	- Mit Alas	7,4	
	Sta Registi		APR 19	2005	istrar's Signatu	April	we								

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** eu Dem 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Center BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 03/10/1934 Birthplace (State or Foreign Country)
 MD Age (In yrs. last birthday) **Funeral** Days Hours Months Min. 216-30-5863 1 M 2 □ F 71 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, Itta Maxical Examines must be nutified at 1 □ Yes 2 □ No Director MD N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 East Fort Avenue 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Navy Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by white 3 Widowed 4 Divorced Korea 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Wire Industry 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Reuben D. Johns, Sr. Ruth E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen J. Johns / Wife 1234 E. Fort Avenue, Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 partial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. April 18, 2005 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature of Euneral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 F. Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Abdominal /Medical ue th (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a constitue ice of) Examiner The law requires that the death certificate be executed the burial-transit nemila and to (or as a consequence of) Division of Vital Records, P.O. Box 68760, this certificate has been signed by the attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy jo Day 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2/**N**0 or Attending Physicien: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident death. 1 TYes 2 □ No within 24 hours after death To the Funeral Director: 3 T Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 17031 10 of death (Item 23a) (Type, Print) 3001 Actuary St, Baltimore, MD. 32. Registrar's Şignature State Registrar

DHMH 17 Rev 1/2001

Sherry Johnson 05-02588 amend /unpend item#20b, 23a, 27, 28a-1, per Fin, Fig. 50435, 5415 Per Are Legible.

State of Maryland / Department of Health and Mental Hygiene O CE crn 1 - For State Registrar 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** ohnson 13 April 2005 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland General Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Days Min. 4ug. Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examinar must be notified at 1 XYes 2 □ No Director Vlarvland more the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a 15 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after o Health and Mental Hygiene. em 27 Is markad other than "natural", or Ital 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnson 19a. Informant's Name/Relationship (Type, Print) (aughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health of 2410 aguira Witranklin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ō Green Mount Crematory permit. Page Department o Important: If any injury or once. 4/22/2005 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of P cility Ave Barto. 222 W. North Part Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Methadone and diphenhydramine Intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: ပို 2 ER/Outpatient 3 DOA X Yes 2 🗌 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28c. Injury at Work? Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 4/13/05 6X Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Boute Number City or Town, State) 1904 McKeen Ave determined 4 Thomicide To the Hospital o within 24 hours aff To tha Funaral Di completely filled in found at home Baltimore, MD 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME Frences April 14, 2005 30. Name and address of person who completed cause of death tem 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
APR 1 9 2005

Greenberg M.D.

32. Regular's Signature

2005

111 Penn Street

Baltimore, Maryland 21201

			For State	State of Maryland /			lental Hygie	n 2 0 0 5	13178						
			RegistrarAMEND TIEM 1. Decedent's Name (First, Middle, La	#8 PER INF G844	6/02/09 ^t 919	t Death	Reg.	No.	To = 10						
	Physici		JAMES	R. JON	ES		Month	Day Year	3. Time of Death						
	/Medio		4a. Facility Name (If not institution, given			, or Location of Death	April	4c. County of Death	11:45 AM.						
				alth. Core.	Balti	une, MD-	21229	NA							
	Funeral			Sex 7. Age (In yrs. last i	birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Ye	dar/	place (State or Foreign intry)						
	Director		236-09-6188 Usual Residence of Decedent	760	713.		NOVEMOCK S	7,1900 W.V	TREINIA						
	Maryland -f show lied at		10a. State 10b. County	10c. City, To	wn or Location	-			10d. Inside City Limits						
	the Maryland r 28a-f show	Director	MARYLAND N/A	BA	LTIMORE	E CITY			1 XYes 2 □ No						
	the Control	Dire	10e. Street and Number	005 AVELUE	10f. Zip Code	011	10g.	Citizen of What Cou	ntry?						
	eath	Funeral	3217 WESTWO	12. Was Decedent Ever in U.S.		Hispanic Origin? (Spe	cify Yes or No	14. Race - Ameri	can Indian						
9			1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑No	If Yes, specify Cu	iban, Mexican, Puerto I	Rican, etc.)	Black, White							
5-0036		d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 N	o Specify:		Specify: Be	IACK						
	n 72 hours "naturel", edical Ex	Completed	15. Decedent's E (Specify only highest gr	ducation 16 ade completed)	ia. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	a during most of working	ng 16b	o. Kind of Business/Ir	ndustry						
2121	filed within Hygiene. other then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	SELECTO	R	1	941							
		Bec	17. Father's Name (First, Middle, Last		Allegan and the second	18. Mother's Name	(First, Middle, Maid	den Surname)							
ylai	2 should be and Mental is marked c	To	JAMES R.	JONES		LULA	1 1 1		DNES						
Maryland	s 1 and 2 should if Health and Men item 27 is marke other treumetic		19a. Informant's Name/Relationship		9b. Mailing Address (Street				Code)						
	s 1 and of Healt item 2 other		77+ELMA E. L. 20a. Method of Disposition	20b. Place	of Disposition (Name of	D		Location - City or To	own State						
Baltimore,	8 ± ± 5		1 Burial 2 Cremation 3 C	Bemoval from State	tery, crematory`or other pi	, I									
alti	permit. Page Department o Importent: if any injury or ance.		*4 Donation 5 Other (Specify) ARBUTUS INVIMORIAL PARK 04-22-2005 BALTIMORIAL PARK 04-												
8	20 = 20		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter the mode of dy	ring, such as cardiac of	r respiratory arrest,		Approximate Interval Between						
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Asporation	prevenor	va.			Onset and Death						
1	Examiner		1	Due to (or as a consequence	e of):	1 Prema									
	100	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	e of):	1 Pheno	mma.								
1	cuted nd ransit	Examiner	that initiated events	c											
60,	oe execian a	EX	resulting in death) Last	Due to (or as a consequence	e of):										
68760,	licate be executed physician and s the burial-transit	edical		d											
Вох	leath certifi attending I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delive	erv						
	that the death cer ed by the attendir detached for use	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Month	Day Year						
P.0	at the d by th etach	Phys	9 Unknown												
	es be		Part II. Other significant conditions of		in the underlying cause g	iven in Part I.	23e. Did tobacc	co use contribute to to	he cause of death?						
Sor	w requir been si should	letec	14.14	Dementra. Jensson:			-								
of Vital Records,	icien: The lav certificate has rector, page 2	Completed	- IT giper	mujon.			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of						
ta	en: T	O	25. Was case referred to medical			26. Place of Death	(Check only one)	No 1 ☐ Yes	2171140						
) \	Physicien: this certificatal director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2 ER/C	Outpatient 3 DOA	ther: 4 - Nursing Hom		6 ☐ Other (Specif	(y)						
n c	ding P		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	(Month, Day Year)	Time of 28c. Injury Wo	ury at 2 ork?	8d. Describe how in								
Division	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b			Yes 2 No	Rf Location /Street	and Number or Rura	d Pauta Mumbas						
Di∨	affer affer Directly	Certification:	4 Homicide determined	building, etc. (Specify)	ami, street, factory, onice	, ,	City or Town, St	ate)	ir Houle Number,						
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge	ge, death occurred at the	time, date and place, a	nd due to the cause	e(s) and manner as s	tated.						
	the H hin 24 the F nplete	Medical	onel	niner: On the basis of examination a and manner stated.	inwor investigation, in my	opinion, death occurre	d at the time, date a	and place, and due to	the cause(s)						
	To wit	Σ	29b. Signature and title of certifier	MA	29c. Licen	ise number	29d. (Date signed (Month,	Day, Year)						
	\	1	30. Name and address of person who	completed cause of death (from 33-	(Type Print)	10013-	A	41 16,2	005						
	1		29b. Signature and title of certifier Musician 30. Name and address of person who Muhamma 31. Date filed (Month, Day, Year) APR 1 9 20	SAM, MAN- STA	snes health to	e you cann	1 Trenue	· Benting	1226						
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	A. M.				1667						
	Registr	ar	APR 1 9 20	Us Korner D.	LOSAL										

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Lam Johnson APRIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore MUD N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months XXM 2□F 212-32-5976 Director 69 Yrs. 01/09/1936 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rel', or items 23e or 28a-f ehov Exerciner must be rictified at Director TY Yes 2 □ No MD N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4416 IVANHOE AVENUE Funeral 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Specify: BLACK 3 Widowed 4 X Divorced naturel the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) WELDER MD DRY DOCK CORP. 9TH Pages 1 and 2 should be filed an nent of Health and Mental Hygie out: If Item 27 is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) HARRY EDWARD JOHNSON 2 SADIE FRANCES AYDLOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY JOHNSON / BROTHER 4002 FAIRVIEW AVENUE, BALTIMORE, MD 21216 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Qurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 permit. Page Department of Importent: If any injury or once. KING MEMORIAL PK 4/18/05 BALTIMORE CO, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or leart failure. List only one cause on each line. Approximate Interval Between Immediat ause (Final disea Onset and Death Physician metastatic luna cancer /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by director, page 2 should be 2 🗆 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No autopsy certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pendina 2 Accident 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerel L (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AU 4176435G14437 AREL/11/05 Soleyan Choves MD 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Soleyan Groves 22 S. Greene St 31. Date filed (Month, Day, Year) 32. Recetrar's Signature State Registrar Jenn & Sperke

		a	mend item#195;9	State of				d Mental Hy	26 05 vt	0.5	13180
	- Character		State Registrer 1. Decedent's Name (First, Middle	, Last)	Ce	ertificate of	Death	2. Date of D	Reg. No. eath Day	Year	3. Time of Death
	Physic /Medi	cal	DELIA 4a. Facility Name (If not institution	ONES	ber)	4b. City, Town, o	r Location of D	april		2005	10:39PM
	Exami	ier	STELLA M	ARIS AT	A A	BAL	Timo	RE		Nla	-
	Funeral Director		5. Social Security Number 227-32-3626	6. Sex 1 M 2 F	7. Age (In yrs. last birthday 78 Yrs.	Months Days	If Under 24 Hours	Ain (Month, D	7 16, 1927	l Country	e (State or Foreign
	tryland thow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L				<i>.</i>	10d	. Inside City Limits
	the Ma	recto	MO wl	A-	N.A.	LT I MOI	CR		10g. Citizen of	What Country	1 ☐ 16 5 2 ☐ No
	after death with the Marylar or Items 23a or 28a-f show mirer must be notified at	Funeral Director	3600 WEST	RANKUN		300 2	1229		UNITE		ATES
36		by Fune	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Privorced	Armed For	2 No	. Was Decedent of H If Yes, specify Cuba 1 Yes 25 No	Specify:	/ (Specify Yes of Nuerto Rican, etc.)	o- 14. Had Bla	ce - American ck, White, etc	
21215-0036	72 hours "natural",	eted	15. Deceden (Specify only higher	's Education	16a. Dec	edent's Usual Occup e kind of work done	during most of	working	16b. Kind of B	usiness/Indus	stry
212	e filed within Il Hygiene. other than vent, II e W.	Completed	Elementary/Secondary (0-12)	College (1-	40r 5+)	STITES	TEA	CHER	PUBLI	e Si	chools
and	2 to 2 2	Be	17. Father's Name (First, Middle,		reom		. 1 .	Name (First, Middle	Maiden Sumar	ne)	
Mary	2 should be and Menta ls marked raumatic so	10	19a. Informant's Name/Relations	nip Syncari	19b. Mai	ling Address (Street	and Number of	Rural Route Numb	V)	4 4 4	^
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ر altimore,	permit. Pages Department of Important: If i any injury or once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	secify)	Green ME		4	.16.05	BALT	·Imoce	, W
Bal	permit Depar Impor any in		21. Sinna ure of Funeral Service	XXXXIIIS	C	22. Name and Addre		LES Bal	saltimore timore		1250
			showk, or heart failure. List	complications that ca only one cause on ea	used the death. Do not en ch line.	nter the mode of dyir	ng, such as car	diac or respiratory	arrest,	A) în	pproximate Iterval Between Inset and Death
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	ing Phys	on: To	27. Manner of Death 1 Natural 5 Pendin	28a. Date of	patient 2 ER/Outpatie Injury 28b. Time Injury Injury	MILL SILL DOA	v at	g Home 5 Res 28d. Describe	idence 6.∠Oth how injury occur		hospice
Division	Attendir death.	ficati	2 Accident Investig	not be 28e. Place of	of Injury - At home, farm, s		Yes 2 □ No	28f. Location	Street and Numb	per or Rural R	oute Number,
Ö	urs afte ral Dir	Cert	4 - Homicide	bullain	g, etc. (Specify)			U.	wn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical Certification:	29a. Certifier 1. Certifyin (Check only one)	g Physicien: To the t Examiner: On the bas and mann	pest of my knowledge, dea sis of examination and/or i er stated.	ith occurred at the tir nvestigation, in my o	ne, date and pl pinion, death o	ace, and due to the ccurred at the time	cause(s) and ma date and place,	and due to the	ed. e cause(s)
	Withi Com	Σ	29b. Signature and title of certifie	~ ~		29c. Licens	e number		29d. Datersigne	Month, Day	y, Year)
1	FO		30. Name and address of person	who completed cause	of death (Item 23a) (Type	, Print)	٢٥٥٦		<u>'</u>		
	Sta	ite	David Rise 31. Date filed (Month, Day, Year)	oerg 301	ST PGUI	Pl Ba	lumo	re ma	1. 712	02	
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiepe 05 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** William E. Kroening 11:15a[™] April 16, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 115 Kinship Road Baltimore Dundalk
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1**2** M 2 □ F 212-58-0794 Director 54 11,1951MAryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Items 23a or 28a-1 ehow othar traumatic event, the Madical Examinar must be notified at 1 Yes X No MD Directo Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Kinship Road 21222 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 57 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other than "natural", or Itel 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Advance Thermal Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Hydrolics 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Kroening MAry E. Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if itam 27 is m eny injury or othar traum once. PAtricia Weaver /sister 647 47th Street Baltimore MD 21222 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition TV Jurial 2 ☐ Cremation 3 ☐ Removal from State Lawn Cemetery 4/19/05 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service License 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or co shock, or heart failure. List on tions that caused the death Approximate Interval Between Onset and Death ot enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Pnysician ana Car cine ma (al Mai /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Tes 2 🔀 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🕱 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) greene street, 59010, Baltimore MARROL Hachem (Meere bourn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 2 State Registrar AMEND ITEM #10a&15 PER FH G842/16/PROF OF DEPARTH 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 16 **Physician** 2005 3:21 P M Joan Marie Kuhn /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 2414 Hartfell Rd. Baltimore Timonium
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 F Yrs Director 577-52-7149 67 April 30 1937 Wash., DC Usuel Residence of Decedent 10a. State MD with the Maryland 10d. Inside City Limits 10c. City, Town or Location or 28a-f show th and Mental Hygiene. It is marked other than "natural", or fleme 23s or 28s-1 ehov traumatic event, its Medical Exactions must be notified at 1 ☐Yes 2 ☐ No Director D€ Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2414 Hartfell Rd. 21093 USA by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "Year or Dates: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Apartment Management</u> Henderson-Webb 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William P. Hudak Kathryn C. Klema 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If Itom 27 Is John Earley Kuhn/husband 2414 Hartfell Rd., Timonium. MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mt.Olivet_Cemetery 4/21/05 Wash. DC 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Service Licensee Michael) J. Flagle 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) anheatre **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician a Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown à been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 DUnknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed certificate 1 Yes 2 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) To 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral dir this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation tilled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 16 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 1 9 2005 State Registrar

			State of Maryland / Department	artment of Health and M rtificate of Death		giene () () 5	13181
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Ye	3. Time of Death
	/Medic		Kingward Kuo	r	SPRIL	15 200	15 142 bm
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of E	Peath
			Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birt	h q	Birthplace (State or Foreign
	Funeral Director		579-66-9362 1\(\mathbb{X}\) M 2□F 74 Yrs.	Months Days Hours Min.	I (Month, Dai	v. Year)	China
	D		Usual Residence of Decedent				
	show	_	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	Directo	Maryland Montgomery North Be			40- 00	
	with t	Dir	10e. Street and Number	10f. Zip Code 20852		10g. Citizen of What	
	leath	Funeral	11710 Old Georgetown Road, #1117 11. Marital Status 12. Was Decedent Ever in U.S. 13.			United St	ates American Indian,
ω.	after o		1 ☐ Never Married 2 △ Married 1 ☐ Yes 2 📉 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		Vhite, etc.
ğ	ours a	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 【 No Specify:		Specify:	Asian
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Σ	and 2			01d Georgetown R		117, N. B	ethesda, MD
Baltimore,	of He of He it item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition 20c. Place of Disposition 20c. Place of Disposition 20c. Place of Disposition 20c. Place of Disposition 20c. Place of Disposition	matory or other place) ADT1	Î ^{ate} 18,	20c. Location - City	or Town, State
Ē	Pag tment tent: tury c		'4 Donation 5 Other (Specify)	11m Inc '4003		Bethesda	Maryland
e B	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itame 23a or 28a-1 show any niury or other treumatic event, ittu Madical Examinational Department on the Concept.			Name and Address of Facility Roberthesda-Chevy Chasethesda, Maryland			consin Avenue
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	To th within To th	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)
	_		I SER M. Whele MC	2438946		APRIL	15,2005
61	r		30. Name and address of person who complete cause of death (Item 23a) (Type,	•			
2	V		JACOB WISBECK MD UNION MEMOTIAL 1 31. Date filed (Month, Day, Year) 32. Signature	HOSPITAL ZOI E. U	UIVEASIT	Y PKWY BE	actimore 21219
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2005 32. Agistrar's Signature	parke			
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			1- State of Maryland / Departm	nent of Health and M cate of Death		e <u>p</u> e 0 0 5	13185
	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Stanley E. Krosin		APRIL	15 2005	5:00 P ^M
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If L	LTIMORE Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMORE 9. Birth	place (State or Foreign
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	or 28a	Director		Of. Zip Code	10	g. Citizen of What Cou	intry?
	23a c	aiD	3 PICASSO COURT	21208		U.S.A.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28e-1 show or other traumatic evant, the Medical Erann at runtil termiliad at	y Funerai	1 ☐ Never Married 2 1 ☐ Yes 2 1 No	Decedent of Hispanic Origin? (Spi i, specify Cuban, Mexican, Puerto es 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WH	
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	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Univerily & Bar	Pal 22	J. Gree)	T. Bulhown
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			For	State of Marylar	nd / Depa		Health and M	1ental Hygi	ene ()) 5	13186
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	/Medic		Lydi	ia Marion L	loyd			April	15 200) 5	J.IJam
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ii.	Director		161-26-8519 ¹	M 2 □XF 9	6 Yrs.	Months Days	Hours Min.	June23		PÄ	lace (State or Foreign htry)
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	ylan		10a. State 10b. County	10c. Ci	y, Town or Lo	cation				1	0d. Inside City Limits
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	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f ahow ta Mudical Examilier main be notified at	ā	3615 Wheelhous	so Road			21220		USA		,
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0	a dea	Sic	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d 9☐ Unknown	eath 5	Other (specify)			MOI	iii)	Day Year
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	hour hour ineri		29a. Certifier 12 Certifying Physi	ician: To the best of my kno	wledge, death	occurred at the tin	ne, date and place,	and due to the cau	ise(s) and mar	ner as sta	ated.
	9 Ho 1 24 9 Fu	Medical	(Check only 2 Medical Examinone)	er: On the basis of examina and manner stated.	tion and/or inv	estigation, in my o	pinion, death occurr	ed at the time, dat	e and place, a	nd due to	the cause(s)
	To the Hospitel or A within 24 hours after To the Funeral Dira completely filled in b	M	29b. Signature and title of certifier	1		29c. Licens	e number	290	d. Date signed	(Month, E	Day, Year)
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	1 - State Registrar				Ce	rtificate c	of Death			Reg. No.		1		
an	1. Decedent's Name (First, Middl								2. Date of Da	15 ^{Day}	200°	ē.	3. Time o	
al	Mary Jeanne La					4b. City, Tow	n or Location	of Death	April		County of D		10:3	U A "
er	4a. Fecility Name (If not institution Lorien Nursing		i number)				mbia	Or Doain			Howar	_		
	5. Social Security Number	6. Sex	7. Ag	e (In yrs. last	t birthday)	If Under 1 Ye	ear If Unde	24 Hrs.	8. Date of Birt (Month, Da	th			ace (State	or Foreign
	219 10 7195	1 ☐ M 2 🔀	F 8	32	Yrs.	Months Da	ys Hours	Min.	July 8		22]		yland	
	Usual Residence of Decedent 10a. State 10b. County			10c. City, T	Town or Le	ocation				10d. Insi			d. Inside C	ity Limits
ō	MD Howai	For		E11	icott	- City							1 🗆 Yes	2 X No
rec	10e. Street and Number	Lu		1-1-1-1-	Ellicott City 10f. Zip Code					10g. Citiz	en of What	t Count	try?	
Funeral Director	3521 N. Chathar	n Road				2	21042			Un:	ited :	Sta	tes	
ē	11. Marital Status		Decedent d Forces?	Ever in U.S.	13.	Was Decedent If Yes, specify C	Vas Decedent of Hispanic Origin? (Specify Yes o Yes, specify Cuban, Mexican, Puerto Rican, etc			- 1	4. Race - A Black, V			
by Fu	1 Never Married 2 Mar	ned 1 TY	es 2⊠n Give	No			☐Yes 2█ No Specify:				Specify:			
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Be	17. Father's Name (First, Middle,						(First, Middle,							
0	Frank Ellwood							eatrice						
i	19a. Informant's Name/Relations					ing Address (Str							Code)	
	Raymond Laverd: 20a. Method of Disposition	iere/Son	<u> </u>			amrock Cosition (Name o			ninster	•	2115 cation - City		wn. State	
	1 ☐ Burial 2 Cremation		rom State	1	·	matory or other		/_10	-2005					
	21. Signature of Funeral Service	1 Burial 24 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify) Metro Crematory 4-18-2005 Catonsville									TTC			
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State Registrar 31. Date filed (Month, Day, Year)
APR 1 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.B. Vellanki 9055 Chevrolet Drive #100 Ellicott City, MD 21042
31. Date filed (Month, Day, Year)
2. Registrar's Signature

ORIGINAL

D 30469

April 18, 2005

DHMH 17 Rev 1/2001

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

		For State Registrar	State of	f Maryla		artment of H rtificate of L		d Mental Hy	giene Reg. No.	2005	13188
Physical		1. Decedent's Name (First, Middle, La	st)					2. Date of De	Day	Year	3. Time of Death
Physici /Medi			4K					04.13		005	4:05 PM
Examir	ier	4a. Facility Name (If not institution, giv FUIURE CARE -				4b. City, Town, or BALTIMO	_	eath	4c.	County of Death	
Funeral		5. Social Security Number 6. S			s. last birthday)	If Under 1 Year	If Under 24 h		th Value	9. Birthp	lace (State or Foreign
Director		093.28.6871	□M 2 ⊠ F	10	Yrs.	Months Days	Hours M	lin. (Month, Da	1934	Coun	MD
and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
Marylan -f show	tor	MD NA		BA	LIMORE	<u> </u>					1 XYes 2 □ No
in the	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Coun	itry?
ath wi		101 N. ARLING				212	* *			USA	
ter des Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece Armed Fo 1 ☐ Yes	rces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	-	14. Race - Americ Black, White,	
urs aft	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Giv Year or D	/8		1□Yes 2 ⊠ No	Specify:			Specify: BLA	CK
be filed within 72 hours after death with the Maryland ital Hygiene. Id expert than "neturel; or items 23e or 28e-f show event, the Medical Examination in the indifficult of	Completed	15. Decedent's E (Specify only highest gra			(Give	dent's Usual Occupa	luring most of	working	16b. Ki	nd of Business/Ind	dustry
within sne.	ldm	Elementary/Secondary (0-12)	College (1		Housi	DO NOT use retired) -		10	NYTORIAL	
filed v Hygie sther	e Co	17. Father's Name (First, Middle, Last	, NI	Н	FIOUSI	CALLYLI	<u> </u>	Name (First, Middle,			•
uld be Mental rked c	To B	DANIEL ALEXAND	ER				ROSA :	JONES			
es 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. If item 27 is marked other than "neturel; or items 23e or 28e-f show it other treumetic event, the Medical Evanter must be multified at		19a. Informant's Name/Relationship (Type, Print)				_	Rural Route Number	-	r Town, State, Zip	Code)
s 1 and the Health item 27 other tr		CATRICE GUYTON 20a. Method of Disposition		20h		N. CAREV	ST.	BALTO. N	-	21217 ecation - City or To	wn State
Pages nent of lint: If its		1 ☐ Burial 2 【Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special		State	cemetery, crer	natory or other place		. 16.05	BAL		Wii, Giato
3 J E E E E		21. Signature of Funeral Service Lice	10	<u> </u> <u> </u>				UNEVAL SE		-	
Depariment of the policy of th		Vaugh (\triangle			51 BALDIN	ATL PIKE	CANDO.	NID	21229	
		23a. Part1. Enter the disease, or comshock, or he in failure. List only	plications that cone cause on e	aused the dea	ath. Do not ent	er the mode of dying	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 14	per	enc	2000					
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icate be executed physician and sthe burial-transit	alE	4	- 1	OI as a collse	squerice of.		1				
ifficate g phys	edical		d								
th cert tendin r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of preg		Ectopic pregnancy			:	23d. Date of delive	*
the at	slcl	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregn 9□Unkno	ant at time of		Other (specify)				Month	Day Year
uires that the death certific signed by the attending of d be detached for use as		Part II. Other significant conditions	contributing to de	eath but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco u	ise contribute to the	ne cause of death?
aures n sign	ed by							10	Yes 2	□No 3 □ Prob	ably 4 Unknown
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The law	Com							perfo	rmed? 2.✓ No	death?	
vicien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		Death (Check only o			
ding Physicien: n. After this certific funeral director,	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	☐ ER/Outpatier 28b. Time o	11 3 DOA	4 LA IAUISIII	g Home 5 Resi			/)
ath.	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	n	th, Day Year)	Injury		<br Yes 2 □ No				
or Attendate death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At ing, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (City or Tox	Street an wn, State	d Number or Rura)	l Route Number,
pitel o		29a. Certifier 1 Certifying P	veicien: To the	hact of my k	nowledge deat	h occurred at the tim	o date and pl	ace, and due to the	causa(s)	and manner as si	atod
To the Hospitel or Attending Physicien: The law requires that the death certification at the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medicel Exer	miner: On the b	asis of examiner stated.	nation and/or in	vestigation, in my op	pinion, death o	ccurred at the time,	date and	place, and due to	the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	number		29d. Dat	te signed (Month,	Dey, Year)
X		When &	5	27,0	~_	1	5421		41	18/05	
3 ·		30. Name and address of person who	completed caus	se of death (Ite	_	•	a He.	11/00		dile 1. A	7 1 777
St.	ate	31. Date filed (Month, Day, Year)	32. R	legistrar's Sig		macue	ب ۱۱۰۰	AV CO	OTIS	-ine, wil	C1210
Regist		API	2 1 9 20	15		4 Snach	1				

State of Maryland / Department of Health and Mental Hygien@ () 1 - State Registrar Certificate of Death Decedent's Narpe (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 14, 8:55F M APRIL 2005 /Medical 4a. Facility Name (Innot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 F Days Hours Director 211-26-223 BALTIMORE. Usual Residence of Deceden with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le markad other than "naturel", or Items 23a or 28e-f show othar treumatic event, the Medical Examinar must be redified at 1 Yes 2 □ No Directo DALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6126 21206 HUR death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 I No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 le marked other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Jife. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be 105 velup. HULMOYER 19a. Info ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town/State, Zip Code) 313 Hookins Kd 20a. Method of Disposition nuLTIMOYE 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Linese BALTIMORE, MD 21234 8800 HARFORD RD CHAPEL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes 2 No Hospitel or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA
ate of Injury
(Month, Day Year) 28b. Time of Injury Other: 2 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) per of ath 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) April 15, 2005 D17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HELDU, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Patricia A. Miller State of Maryland / Department of Health and Mental Hygiene For State Registrar 05-2619 Certificate of Death AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Patricia A. Miller <u> April</u> 14, 2005 8:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bon Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛚 F Days Hours Yrs. Director 213-96-1845 39 May 12, Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Madical Experiment, ast be notified at 1XXYes 2 ☐ No Director NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1930 Frederick Avenue 21223 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: Black <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be tiled with and Mental Hygien 7 is marked other th Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roosevelt Stuckey ဂ္ Elizabeth Stuckey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum once. Charles Miller/ Husband 1930 Frederick Avenue Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 04-19-05 Mt. Zion Cemetery Lansdowne, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility meda Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Candiovascular disease ble to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, in the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and tor use as the burial-transit law requires that the death certiticate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown À signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Diabetes melletus, morbid Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Whis an has certificate 1 🗌 Yes Vital 2 🔀 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XEP/Outpatient 3 ☐ DOA 1X Yes 2 □ No Division of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Atter t Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after on Funeral Direct 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME April 15, 2005 reenberg hin

State Registrar 30. Name and address of petron

31. Date filed (Month, Day, Year)

APR 1 9 2005

DHMH 17 Rev 1/2001

111 Penn Street

Baltimore, Maryland 21201

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

State of Maryland / Department of Health and Mental HygieRell 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Marie T. McCauley 2. Date of Death 3. Time of Death Month **Physician** 2005 3:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital

7. Age (In Vrs. last birthday) KOSEGA E If Under 1 Year If Under 24 Hrs. Baltimore Franklin QUAYE 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1□M 2√F 215-30-1410 Director 27,1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic svant, the Madical Examiner must be notified at 1 Yes 2 No MD N/A Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ď 1339 Andre Street 21230 United States Funeral or itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Accounting Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 99 Frank Huster Unk. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. McCauley, Sr. / Husband 1339 Andre Street, BAltimore MD 21230 if item 27 i othar Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State injury or Bay View Crematory 04/13/2005 Baltimore, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Victor P. Doda, Jr.

22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPOXIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pleural EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed burial-transit T) Due to (or as a consequence of): Box 68760, physician Physician/Medlcal Cancer IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) o detached 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably A Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed? Vital 1 ☐ Yes 2/2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 3 No No Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? s after death. ai Diractor: After t 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred Division or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha To the 29c. License number 29d. Date signed (Month, Day, Year) D0062373 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, MD 2123 31. Date filed (Manual

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

State of Maryland / Department of Health and Mental Hygien - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 11:40 " latthe Sanda 2005 pr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dipath Examiner Baltimore Hospita The Johns Hookins If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign 7. Age (In yrş. last birthday) 6. Sex 5. Social Security Number **Funeral** Days AAD-84-835 Usual Residence of Decedent 1 □ M 2 🔽 F Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10b. County Town or Location 10a. State 1 Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Blvd. I) Son Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give 4. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mo ner's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be 0 19b. Mailing Address (Street and Number - Rural Route Number, City or Town, State, Zip Code, Informant's Name/Relationship (Type, Print) 20b. Place of Disposition cemetery, crematory 10 (Name of y or other place) Date 20a. Method of Disposition 20c. Location - City or Twn, State 1 Burial 2 Cremation 3 Removal from State 12005 emetery * 4 □ Donation 5 □ Other (Specify) 00 21. Signature of Funeral Service Licenses Name and Address A acility Ito me Funeral 05 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Encephal opath **Physician** da4 resulting in death) /Medical Due to (or as a consequence of): Examiner ortec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exacts. Be Completed by Physician/Medical Examiner Due to (o) as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 | Fetal death Month Day Year in the past 12 months? ō 4 Pregnant at time of death 5 Other (specify) P.O. I ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 🗆 No 2 🗆 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 1 Impatient 2 ER/Outpatient Certification: To this 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in extraction death. Medical 29a. Certifier Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RFS-006 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Wolfe Mary land 00 31. Date filed (Month, Day, Year) rebauer 6 32 Registrar's Signature State APR 1 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierje 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month Day Year 11:10 PMM **Physician** 2005 יתקל /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ma Itimo If Under 24 Hrs. 9 Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday, **Funeral** Hours Mary -38-1 M 2 □ F Yrs. Director ana Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Jamit. Pages 1 and 2 should be mey mine.

Department of Health and Mental Hygiene.
Important: If item 27 ie marked othar than "natural", or itama 23a or 28a-f show important: If item 27 ie marked othar than "natural", or itama 23a or 28a-f show injury or othar traumatic event, the Madical Examinet count for nothing at 1 Yes 2 □ No **Funeral Director** Maryland more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 695 2 Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 2 No 1 🗌 Yes Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) el 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ emue 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Competery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Park 22/2005 4 Donation 5 Other (Specify) 22. Name and Address of Facility oseph L. RUSS 21. Signature of Funeral Service Licensee Funeral Home, Approximate Interval Between Onset and Death Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 2. No 1 🔲 Yes Division of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) Hospital: ပ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA filled in by the funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1- Natural death. 1 🗌 Yes 2 🗌 No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To tha Funaral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who come

APR 1 9 2005

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

V0

29c. License number

29d. Date signed (Month, Day, Year)

5

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 5 1- State Amend Item 5 per fh G842 4-22 Of title ate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** April 12^{ay} 2005 Patricia B. Mesmer 1:55pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 942 Homberg Ave. Baltimore Essex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | OCT 13, 1928 | WestVirginia 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F Yrs. 76 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No MD Baltimore Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 942 Homberg Ave. 21221 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene al Hygiene. I other then "neturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi and Mental F is marked of Harry Blackshire Sarah Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Dodd C. Mesmer/husband 942 Homberg Ave. Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Pages 1 Department of h Importent: If ite any injury or ot 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State HollyHillCeme tery 4/15/05 Baltimore MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or conshock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Parcentic Immediate Cause (Final Pnysician Carrer-2 month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the b IF FEMALE: esn. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes 2 0 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Matural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical npletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m 23a) (Type, Print) State Registrar

Please Type of Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Tack Yea **Physician** 11051 2005 H pri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Care timore Ture 9h ing 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) SOUTH CAROLIN 5. Social Security Number **Funeral** Months Days Hours Min. UNKNOWN 1XM 2□ F 82 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County worls iral, or itams 23a or 28a-f show Examiner must be notified at XXYes 2 □ No BALTIMORE CITY Directo MD N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 2836 KENTUCKY AVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 【☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK 3X Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, I've Madical 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Coilege (1-4or 5+) and Mental Hyglene. LABORER LABORER UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOTTIE (UNKNOWN LAST NAME) ပ (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2836 KENTUCKY AVE, BALTIMORE, MD 21213 Health tam 27 SADIE BOYD / DAUGHTER itam 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ot: 1 ☐ Burial 2X Cremation 3 ☐ Removal from State METRO CREMATORY 4/19/05 CATONSVILLE, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each dee. Approximate Interval Between Onset and Death immediate Cause (Final Enysician Atherose ardi 10501 disease or condition resulting in death) 10000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in hierarchicause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner hysician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 No certificate Division of Vital Yes tha Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 ☐ Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1. Natural 2 Accident Injury 5 Pending death. 1 Yes 2 No investigation after death within 24 hours area. _____
To tha Funaral Diractor ______ 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number Dolphin st, Balto, MD 21217 lagen mater 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATEM 31. Date filed (Month, Day, Year) Registrar's Signature State APR 1 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Tommy Massey March 31 2005 9:45 PM /Medical 4a. Facility Name (If not institution, give street and number)
CASEY HOUSE 4c. County of Death Montgomery 4b. City, Town, or Location of Death Rockville Examiner 7. Age (In yrs. last birthday) 70 Yrs. 5. Social Security Number 263-46-0836 If Under 1 Year If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 M 2 □ F Director 1934 Florida June 16, Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. In Medical Evantment be notified at ODEs. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery Silvers Spring 1 Yes 2 No Director 10g. Citizen of What Country?
United States 10f. Zip Code 20905 10e. Street and Number 262 Amberleigh Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⑤No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Government Printing Off 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unk. Unk. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 262 Amberleigh Drive Silver Spring, MD 20905 Deloris K. Massey/ Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Glenwood Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/05 Washington, DC ' 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th St. NW Washington, DC 20011 23a. Part1. Enter the state ase, or complicate a state of the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or he a failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 Month Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Carcinoma /Medical Due to (or as a consequence of): Examiner Lung Cancer 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy ZENO 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Casey House Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 承No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 KNatural 1 ☐ Yes 2 ☐ No Director: completely filled in by the 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D09470 April 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10901 connecticut Ave. Kensington, MD 20895 Eugene P. Libre MD book 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 16, Daz 2005 Year **Physician** 12:30 а м Joseph Carl Mannherz, Sr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 205 Crosse Pointe Court, Unit 1C Abingdon Harford 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 77 | Yrs | Months | Days | Hours | Min. | October 1, Year 927 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** 1⊊M 2□F Austria 218-22-8835 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or tiems 23s or 28e-f ehow amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Director Harford Abingdon Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21009 205 Crosse Pointe Court, Unit 1C Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 No Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☒ No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cable splicer communications 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Mannherz Mary Heindl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Crosse Pointe Court, Unit 1C, Abingdon, Md. Nadine H. Mannherz/wife 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 4/20/2005 Baltimore, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ²² Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANGI 9 MONTHU CONCET /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed Box 68760. Due to (or as a consequence of): physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Tetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 No 1 Tyes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury To the musping after death.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicism. To the best of my knowledge death occurred at the time, date and place, and due to the dauto(c) and internet at stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 038409 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print) SharFnav 10753 Falls Res # 417 Comerille Med 21093 William . Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

APR 1 9 2005

Brian Montes 05-02526 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		irtment of H tificate of I		fental Hygie Reg.	2000	13198
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Ye	3. Time of Death
	Physici /Medio		Brian A. Mor	tes				April 11	. 2005	0437 A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
			Johns Hopkins Hos			_Baltimo			N/A	
	Funeral Director		214-23-3137	9X M 2□ F 7. Age (In yrs. 16	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye June 27,	⁹ 988 M	Birthplace (State or Foreign Country) Aryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Manyl 1 ehc	ō	Maryland N/A		-	ultimore				1 ☑ Yes 2 ☐ No
	28a-	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
	3a or	ā	5111 Anthony Av	е.ии.е.			21206		U.S.A.	
	ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - A	mericen Indian,
21215-0036	d within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-f ehow It e Macilical Examinat must be nuffied at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		Yes, specify Cuba	in, Mexican, Puerto Specify:	Hican, etc.)	Specify:	/hite, etc. White
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occupa	ation during most of work	ina 16t	. Kind of Busine	ss/Industry
7	E = 2	npi	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work			
2			17. Father's Name (First, Middle, Last)		Stua	ieni	40. Markada Nasa		High Sc	nook
anc	ntal H ed of	Be	Joseph G. Mon	tox			Bernad	e (First, Middle, Maid Lino Gh	attan	
Ž	should be tind Mental I	င္	19a. Informant's Name/Relationship (7		10h Mailin	a Address (Street		al Route Number, Ci		a Zin Cada)
Maryland	d 2 sho th and th and traum		Bernadine Eisler	(mother)				Baltimore	-	
	ges 1 and 2 should be filer t of Health and Mental Hyg If item 27 is marked othe or other traumatic event,	1 3	20a. Method of Disposition			sition (Name of natory or other place			Location - City	
Baltimore,	permit. Pages Department of H Important: If its any Injury or of		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			natory or other piac Cemetery		/2005 Bo	ultimana	. Maryland
量	nit. Flantmoortar		21. Signature of Funeral Service Licen			_		imunek Fu		, ,
m	Depar Depar Impo any Ir once.		Buin a le	uller	97	05 Belai	r Rd., Ba	itimore,	MD 2123	6
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to immediate cause. Enter Underlying	a. Coutoct Due to (or as a consect) Due to (or as a consect)	3ULSL juence of):					Approximate Interval Batween Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consect	uence of):					
Ψ		0	IF FEMALE:	23c. If yes, outcome of pregna	ancv				22d Date of	dalisans
.O. Box	that the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Δ.	law requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did tobac	co use contribut	e to the cause of death?
rds	n sign							1 ☐ Yes	2 🕱 No 3 🗆	Probably 4 Unknown
ecords,	aw requii is been s 2 should	Completed						24a. Was an	24b. Were	autopsy findings available
α	The his age	E						autopsy performed Yes 2	? death	to completion of cause of i? 'es 2 \sumbed No
Vital	ician: T certifical rector, p	Bec	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	<u> </u>	
of V	90 (0)	္န	1X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 2	ER/Outpatient	1 3□ DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗆 Residence	6 □Other (S	pecify)
		 	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (vonth, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how in	njury occurred	Cal L
sio	Attending r death. ector: Afte by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	4/11/05	Found 3:		Yes 2 No	Susled	suct	sury
-	i e i c	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	y)	,		City or Town, Si	tate)	Rural Route Number,
_	pital ours s eral filled		29a. Certifier t ☐ Certifying Ph	/sicien: To the best of my kno	111 0	occurred at the tim	ne date and place			altimore, MD
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		iner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my or	pinion, death occurr	ed at the time, date	and place, and	due to the cause(s)
	To th within To th	₩ W	29b. Signature and title of certifier	0 1 2		29c. License	number	29d.	Date signed (Mo	onth, Day, Year)
)	£		> Zalvise	Mas Al	r	OC	ME	Apı	ril 11,	2005
	H		30. Name and address of person who a	completed cause of death (Item	n 23a) (Type, I		enn Stree	et Baltim	ore. Ma	ryland 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
	Registr	X-	APR 1 9 2005	Beau 15	BOOM	U			-	
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State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mitchell 6:10 PM Emma 1, 2002 ton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville Hom (SWOI) Zicharen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F 219-20-8474 Yrs. 9/4/1911 MARYLAND Director 93 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ir than "natural", or items 23a or 28e-f sho If e Medical Examinationst be notified at 1 Yes 2 No Director CARROLL MARYLAND MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21784 7200 3RD AVENUE death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) YEARS Elementary/Secondary (0-12) CLERK STEEL FACTORY permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If Item 27 is marked other the eny injury or other traumatic event, Ita once. other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) EMMA SHAW JAMES D.M. MARQUETTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 SMETON PLACE #203 TOWSON, MD 21204 MARGARET GRONAU/DAUGHTER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1- Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 4/21/2005 BALTIMORE, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia Physician ZYODI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month jo 4 Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☑ No 4 Jursing Home 5 Residence 6 Other (Specify) this After this funeral of 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 18,2005 00059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onne. Abel Mo 295 Storer Ave. 367 Westminster 31. Date filed (Month, Day, Year) 32. Registrar Signature State Bleen & Species Registrar

05-2538 B.K.S WILLIAM MOORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stata Registrar	Ce	ertificate of Death	nemai mygie Reg.	2000 10200
	Physici		1. Decedent's Name (First, Middle, Last	Moore		2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give 1306 NORTH MONTFO		4b. City, Town, or Location of Death BALTIMORE CITY	APRIL	11, 2005 1436 P M 4c. County of Death
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs. last birthday		8. Date of Birth	9. Birthplace (State or Foreign
	Director	•	Usual Residence of Decedent	. 10		4-11-2	35 North Carolina
	Marylar Iled at	tor	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits 12€es 2 □ No
	with the a or 28s	Direc	10e. Street and Number	Mandetand	10f. Zip Code	10g.	Citizen of What Country?
	er death	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9036	ours afte	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 □ Mo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ X o Specify:		Specify Black,
215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Exatritue must be medified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+) 16a. Dece (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16t	b. Kind of Business/Industry
7	should be filed within Mental Hygiene. Marked other than Imatic evant, Liv M		17. Father's Name (First, Middle, Last)	tat	hology ASSIST	e (First, Middle, Mai	Health Care
Maryland	d ta b	To Be	Lawrence Ma	pore_	Mani	e Wil	liams
	1 and 2 sh Health and em 27 Is m ther traum	1	19a. Informant's Name/Relationship (Ty	odard 603	33 Wandering	al Route Number, C.	ity or Town, State, Zip Code) 300 93
altimore,	Pages 1 and of He int: If item iry or oth		20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State 20b. Placa of Disp	osition (Name of amatory or other place)	Date 200	c. Location - City or Town, State
Baltir	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic ones.		21. Signature of Funeral Service Licens	" I I I	2. Name and Address of Papility	16/05 IX	eral Services
	403.40		23a. Part1. Enjor the disease, or compleshock or heart failure. List only of	icalions that caused the death. Do not en	ter the mode of dynam such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hypertersive a	theroschootie (prelievasal	Onset and Death
ľ	Examiner		Sequentially list conditions,	Due to (or as a consequence of):			
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
68760,	rtificate be executed ng physician and i as the burial-transit		resulting in death) Last	Due to (or as a consequence of):			
_	ertificate ling physe as the	Medic	IF FEMALE:	2- 4			
.O. Box	The law requires that the death cer tie has been signed by the attendin page 2 should be detached for use	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No		□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delivery Month Day Year
С.	res that the de signed by the a be detached t	by Phy	9 ☐ Unknown Part II. Other significant conditions con	ntributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	w require been sig should b					1 🗆 Yes	
		Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 12 1 Yes 2 Who
Vita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	(Check only one)	e XXOther (Specify) AT SCENE
Division of Vital	or Attending Physician: uter death. Director: Atter this certifica in by the funeral director, i	ion: To	27. Manner of Death 1 ∰Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how i	
ivisio	after death. after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	Hospital o		29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my knowledge, deat	th occurred at the time, date and place,	and due to the caus	e(s) and manner as stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2X Medical Examination (Check only one)	nar: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr		and place, and due to the cause(s) Date signed (Month, Day, Year)
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D	17		THE ODORE M.	mpleted cause death (Item 23a) (Type,	Print) 111 Penn Stree	et Baltin	more, Maryland 21201
	ξ Sta Registr		31. Date filed (Month Pay, Year) 20	05 32 Registrar's Signature	rade		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** NEVADA W. MOORE 2005 10:56 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NA 4302 FAIRVIEW AVENUE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 KF 243.40.6630 93 Yrs. NC Director 07-10. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director NIA 1 X Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4302 FAIRVIEW AVENUE 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: BLACK δ 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. LAUNDRY WORKER 11 /H GRADE NA LAUNDRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be FRED WILLIAMS MOVE MANDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 Is eny injury or other tracent 4302 FAIRVIEW AVE., BALTIMORE, MO DORIS MAYE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State SUN SET CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 04.23.05 FARMVILLE VAUNTHAND Address of Eaching FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MO 23a. Pa.11. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset_and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٩ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: Division 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32. Registrar's Signature

State Registrar Leslie S. Ko 31. Date filed (Month, Day, Year)

MADDEN, WILLIAM Baltimore Maryland 21215-0036

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Fune			5. Social Security Number 6. Se	ex l f. Age (In yr	. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth Cou	oplace (State or Foreign untry)
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/land		-	10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
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er des Items		nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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yid nould i Men narke	1	၉	David Larri	y Madder			Donna	Laron	in hac	Ker:
Daltimore, Maryland ZIZID-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. The property of the marked other than "natural, or Items 23e or 28a-1 show any niqury or other tearmatic event, the Marked Example motified an			19a. Informant's Name/Relationship (7	addo a	19b. Maille	Address (Street	and Number of Hur	al Houte Number, C	ky or Town, State, Zi	M (- 21.2.2
1 and 1 health tem 27		- }-	20a. Method of Disposition	200.	Place of Dispo	sition (Name of		Date 20	c. Location - City or T	Fown, State
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			23a. Part1. Enter the disease, or compshock, or heart failure. Listonly	olications that caused the de	ath. Do not ent	er the mode of dyin		or respiratory arrest		Approximate Interval Between
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12			30. Name and address of person who	berg 301	(Type,	1 O1 6	3011.000	we mal	. 717	03
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State of Maryland / Department of Health and Mental Hygiene | | |

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	Funeral		5. Social Security Number		Sex 1 □ M 2 🖾 F		. last birthday)	If Under 1 Yes Months Day		(Month, Day	Year)	9. Birthpl Coun		or Foreign
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P	d of H	Be	17. Father's Neme (First, M	liddle, Les	t)				18. Mother's Nar	ne (First, Middle,	Maiden Surnan	10)		
Z	Men Men marke	2		uman	Ray	Lin	ndsay		'	da Bowe				
Jar	s 1 and 2 should be filed within f Health end Menlel Hygiene. tem 27 Is marked other than "		19a. Informant's Name/Re		(Type, Print)				et and Number or Ru					
	and fealth m 27		Chad Morela	nd	Son	201-			Chapel Ro		minster			57
ō	ges tof t		20a. Method of Disposition 1 XBuriel 2 ☐ Crem	etion 3 [☐Removal from	State 200.	cemetery, cre	osition (Name of metory or other p	place)	Date	20c. Location	City or To	wn, State	
Ë	tman tant:		4 □ Donation 5 □ Of	15-10-1		Ev		n Mem.	Park	4/19/05	Finksl	ourg.	MD	
Baltimore,	permit. Peges 1 and 2 Depertment of Health e Important: if Item 27 is any Injury or other tra once.		21. Signature of Funeral S	ervice Lice	nsee	-	2:	2. Name and Add	dress of Facility 118	324 Reist	erstown	n Road	d	
	00 = e a		Sams	1	Kin	ė	E1	ine Fun	eral Home	Reister	stown,	MD :	21136	
		/	23a. Part 1. Enter the diser shock, or heart failure	ese, or only	one cause on e	aused the dea ech line.	th. Do not en	ter the mode of d	lying, such as cardiac	or respiratory are	est,		Approxima Interval Be	etween
	Physician		73)		0		1					i	Onset and	Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)		a Pav	Crea	JEC	Cance	er			i.	4 ye	ar5
		<u>.</u>	resulting in dealing			Due to (or as a conse	quence of):					·	
	nsit	Medical Examiner			b					· · · · · · · ·		-		
	ficeta be axecuted 3 physician and as the burial-transit	Xar	Sequentially list conditions if eny, leading to immediat cause. Enter Underlying Cause (Disease or injury that initieted events	ė		Due to (or as a consec	qu <i>e</i> nce of):				i		
260	siciar Siciar	Ca	Cause (Disease or injury that initieted events	~	c	Due to /	or es a consec	unance off:				-		
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Box	eath certifi attending I for usa as	2			d									
	death e atte	sicia	Part II. Other significent co	nditions	contributing to de	eath but not re	sulting in the u	nderlying cause	given in Part I.	23b. Did to	obacco use co	ntribute to	the cause	of death?
Q.	as that tha de igned by the a be datached t	Physician/								1 🗆 Y	es 2□ No	3 Prob	ably 4	Unknown
	as the gned be de	þ												
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ပ္ပ	a law r has be je 2 sh	Completed										of c	mpletion of death?	cause
<u> </u>	a - 0	Sol								1EY	95 2 MU	1 🗆	Yes 2	□ No
of Vital Records,	Physician: Tha i rthis cartificata ha	Be	25. Was case referred to n examiner?	edical	Hanning.					ath (Check only or	16)			
5	his id	٩	1 Ø Yes 2 □ No				ER/Outpatie	N 3LI DOA		ome 5 Resid			1)	
Ë	Ing	0		ending		h, Dey Year)	28b. Time o Injury	W	lork? □ Yes 2 □ No	28d. Describe h	ow injury occur	rea		
Si	Attending in deeth.	Cat	3 Suicide 6 □	nvestigatio Could not t	De 00 - DI	of Injuny - At h	ome farm st	reet, factory, offic		28f. Location (S	treet and Numb	per or Rura	l Route Nu	mher.
Division	al or Attending P s aftar deeth. Il Director: After to ad in by tha funera	Certification:	4 ☐ Homicide	determined		ng, etc. (Speci		oot, radioty, onle		City or Tow	n, State)			
	Hospital or 24 hours afte Funeral Dir stely fillad in	Sign							time, date end place					
	To the Hospital or Attend within 24 hours aftar deet. To the Funeral Director: , completely fillad in by tha '	edlcai	one)		and man	asis of examination of the stated.	ation end/or in		y opinion, death occu					
	To the I	Σ	29b. Signature end title of	ertifier				29c. Lice	nse number	2	9d. Date signe	d (Month, L	Dey, Year)	
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	Sta Registi	_	APR		2005	alless.	K A	redi						

		-	- FOI	partment of Health and M ertificate of Death		ene 005	13204
1	Physicia		1. Decedent's Name (First, Middle, Last) ALF (ZED) NAGENG	AST	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1 .
		2	Genesis Eldercare-Perring Parkway	Baltimore		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 ☐ F 7. Age (In yrs. last birthd Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Oct. 17,	(ear) 9. Birtho Cour 1924 Mary	place (State or Foreign http) Land
	and	}	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town o	Location		1	IOd. Inside City Limits
	Maryl -1 sho	to	Maryland Baltimore	Perry Hall			1 ☐ Yes 2 🔀 No
	th the	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	ntry?
	23a c	rai	9606 H Haven Farm Road	21128		u.s.A.	
20	be filed within 72 hours after death with the Maryland ital Hygiene. In the "naturel", or items 23a or 28a-f show to other then "naturel", or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ 11	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f Yes 2 X No Specify: 	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
2	n 72 hou "nature	Completed	15. Decedent's Education (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired)	ng 16	6b. Kind of Business/In	dustry
717	filed within Hygiene. Ither then "		Elementary/Secondary (0-12) College (1-4or 5+)	.countant	B		acturing Co
2	d be fi	To Be	Alfred G. Nagengast, Sr.	Elizab		beling	
<u> </u>	ges 1 and 2 should be t of Health and Menta if item 27 is marked or other treumatic ev	Ĕ	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rura			
Ž,	サイトサ		5 5	6 H Haven Farm Rd.,			
pallillore	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other ODCs.			crematory or other place)	-7-2	oc. Location - City or To altimore, I	
Dall	permit. Departr Importe any inji		21. Signature of Fuheral Service Licensee	22. Name and Address of Facility Sch 9705 Belair Rd., Ba			es
			23a. Part 1. Briter the Usease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Phal disease or condition resulting in death)	age Denen	L.a.		ylung
	/Medical Examiner		Due to (or as a consequence of):	8			8
L	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
,	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events c				
00/00	ificate be executed g physician and as the burial-transit		d d				
0	*= CD m	l edicai					
J. DOX	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	/sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ery Day Year
, T	ss that the	by Physi	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did toba	cco use contribute to the	
ecords	equire sen sig	ted	Citeroscient C Ca	rdorosulus d'am	1 Tes	2 No 3 Prob	pably 4 Minknown
ž Ž	has e 2	ompieted	meu non's	1 011	24a. Was an autopsy performe	prior to co	ppsy findings available mpletion of cause of
<u> </u>	n: The licate r, pag	O	14 2 Kakeles	"well for	1 Yes 2 4	No 1 ☐ Yes	2 No
VII	s certil	o Be	25. Was case referred to fieldical examiner? 1 Yes 2 Ng Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death		ce 6 ☐Other (Specif	(v)
0 00	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	tion: T	27. Manner of Death 1	e of 28c. Injury at 2	28d. Describe how		
DIVISION	l or Atter after dea Director I in by the	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	Hospite 24 hours Funerel	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o				
	To the within Fo the comple	Med	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	
)	. \		Allow Ciotas	208358	A	PRIL 18	2005
	Let		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) 8903 HA	RFOR	PRIL 18 POST	D 2/23,
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	CAUI MORE	= MA	TOAT	14
	Registr	ar	APR 1 9 2005 Heading 15 10	15-14-			

			For State of Maryland / State of Maryland /	Department of Hea Certificate of De	•	/giene 05 (3205
	- D		1. Decedent's Name (First, Middle, Last)		2. Date of Do	eath 3	3. Time of Death
и	Physicia /Medic		George F. Nislei	n	April	1 ^{Day} 2005 ^{ar}	2:00 A.M
}	Examin		4a. Facility Name (If not institution, give street and number) 3107 Peverly Run Road	4b. City, Town, or Loc Abingdo		4c. County of Death Harford	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 14 38 6053		Under 24 Hrs. 8. Date of Bi Hours Min. (Month, Di July 2	orth 9. Birthplace Country) 20, 1940 Mary	e (State or Foreign
	D .		Usual Residence of Decedent				
	anylar show	7	10a. State 10b. County 10c. City. Tow			10d.	Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	Maryland Harford Abi	ngdon		40.000	_ A
	with le or		3107 Peverly Run Road	10f. Zip Code 21009	0	10g. Citizen of What Country	f
	ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.				Indian.
5-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other then "neturel", or items 23e or 28e-f show marked other then "neturel", or items 23e or 28e-f show imatic event, If a Medical Evertimating transition of the modified at	by	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Noivorced Year or Dates:		nic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	Black, White, etc. Specify: White	
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation	n most of working	16b. Kind of Business/Indus	try
2	ithin ne.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during life. DO NOT use retired) Machinist	ig most of working	17	
2	led w lygier her th		1.7th 17. Father's Name (First, Middle, Last)		Name of the second second	Western Elect	ric
Maryland	should be find Mental Harmarked of	To Be	Michael Nislein	18.	. Mother's Name (First, Middle Eva Willian		
Mar	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatice		T	o. Mailing Address <i>(Street and I</i> 107 Peverly Rui		oer, City or Town, State, Zip Co gdon, Maryland	,
altimore,	of Hei of Hei fitem		20a. Method of Disposition 20b. Place of cemeta 1	of Disposition (Name of ary, crematory or other place)	Date	20c. Location - City or Town,	State
Ĕ	permit. Pages Department of Important: If it any injury or o		Laborial 2 Cremation 3 Premoval nom State	Cross Cemetery		Baltimore, Ma	
3alt	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licensee			neral Service,	
00	205 29		Much gramerousae			timore, Maryla	
l,			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.		*6	A Int	proximate erval Between iset and Death
	Physician :		Immediate Cause (Final disease or condition resulting in death)	-vice Card	Longolla	discores	oot and bount
	/Medical Examiner		Due to (or as a consequence	of):			
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):			
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287	cate phy:	edlcal	d				
Box	death certifi e attending p	M/U	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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J.	at the de by the a	hys	9 ☐ Unknown				
	The law requires that the te has been signed by the age 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting i			tobacco use contribute to the co	
ecords,	w require	ted	antic Valvulor dir	last	10	Yes 2 No 3 Probably	4 Unknown
<u>မ</u>	e law has b je 2 st	Completed			24a. Was	psy prior to comple	findings available stion of cause of
<u> </u>	(d) 17	Co			perio	ormed? death? 200 No 1 ☐ Yes 200	No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? Hospital:	Other	. Place of Death (Check only of		
o	r this	-	TATES 2 NO 1 Inpatient 2 EH/OL	Itpatient 3 DOA 28c. Injury at	Nursing Home 5 Resi	dence 6 Other (Specify) how injury occurred	
0	th: : After funera	atlor	11 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	njury Work? M 1 ☐ Yes		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
S	tten death tor:	0	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office	28f. Location (Street and Number or Rural Ro	ute Number
>	4 - 9 9	-	4 ☐ Homicide building, etc. (Specify)		City or To	wn, State)	ato i tarriour,
Division	tel or At s after o el Direct ed in by	Certif					
A C	ne Hospitel or A 124 hours after ne Funerel Direc tetely filled in by	edical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledgrees of examination are and manner stated.	e, death occurred at the time, dangled or investigation, in my opinion	late and place, and due to the on, death occurred at the time,	cause(s) and manner as stated date and place, and due to the	1
NO.	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical Certif	29a. Certifier (Check only (Check only (Medical Examiner: On the basis of examination ar	e, death occurred at the time, de id/or investigation, in my opinior 29c. License nun	n, death occurred at the time,	cause(s) and manner as stated date and place, and due to the 29d. Date signed (Month, Dey.	i. cause(s)
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NG .	To the Hospitel or A within 24 hours after to the Funeral Direct Completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	29c. License nun	n, death occurred at the time,	date and place, and due to the	i. cause(s)

			1 - For State Registrar	State of Ma	arylan		artment rtificate			and M		giene Reg. No	. 000	13206
	Physicia	an	1. Decedent's Name (First, Middle, L								2. Date of De Month	ath Da	y Yeer	3. Time of Death
	/Medic		Viola (Jwens			4 0 7		1		APRIL	14	2005	7100 AM
	Examin	er	4a. Facility Name (If not institution, g 53 CABLE HOLLOW	WAY			1	RGO	Location of	r Death			C CO	etn
-	Funeval			Sex 7. Aq	e (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir	th	9. B	rthplace (State or Foreign
	Funeral Director		217-22-7022	1 T 11 0 X 5	9	Yrs.	Months	Days	Hours	Min.	(Month, De FEB. 1	y, Yeer)) (Country) VA
	pun 🖈 🗀		Usuel Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation							10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f e how rimes be codiffied at	ļo		G. CO.	700.01									1 XYes 2 No
	28a-	Director	10e, Street and Number	3. 00.		LARGO	10f. Zip	Code			1	10g. Ci	tizen of What C	country?
	3a or		53 CABLE HOLLO	ALI LIAN			20	774					USA	
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13.	Was Decede	ent of His	spanic Drig	gin? (Spi	ecify Yes or No Rican, etc.))-	14. Rece - Am Black, Wh	
ŏ	or the		1 ☐ Never Married 2 ☐ Married	If Yes, Give	No		1 ☐ Yes 2		Specify:	, 1 00110	1110411, 010./		Specify: BI	
2-003e	72 hours after nature!', or ite	ed by	3	Year or Dates:	-	162 Dage	dent's Usua	f Dooupa	tion		<u>.</u>	165 4		
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Mar	12 sho		19a. Informant's Name/Relationship			19b. Maifir							or Town, State,	
e,	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene I Health and Mental Hygiene I Health and Mental Hygiene I netweet, or itema 23s or 28s-f show other traumatic event, i.e. Medical Eventions into the trolline and		RITA E. ALEXANDE 20a. Method of Disposition	R/DAUGHTER	20b. P	Place of Dispo	53 CA	BLE	HOLL		AY, LA		MD 207 ocation - City o	
2	ages int of t: If it y or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			emetery, crer RBUTUS	matory or oti	her place		/10/	2005			
Saltimo	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other ance.		21. Signature of Funeral Service Lic		111		2. Name and	d Address					TIMORE,	
Ď	Department of the control of the con		Lames a.	Worten			1701 I	AURE	ENS S	$\frac{\mathrm{JAM}}{\mathrm{TREE}}$	T. BALT	TORT	ON & SO MD 212	NS F.H., INC
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	/Medical Examiner		resufting in death)	Due to (or as	a conseq	uence of):	4							20.00
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ď	an an rial-tr		resulting in death) Last	Due to (or as	a conseq	uence of):								
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ŏ ×	he death certifica r the attending ph ched for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of precos	nocy							0015-11	
DOX	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 ☐ Feta	fdeath 3	Ectopic pre					į.	23d. Date of de Month	Day Year
j	the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown			(-/	//						
ν L	The law requires that the death ale has been signed by the atter bage 2 should be detached for u	by P	Part II. Other significant conditions			-		_	4		17.5		1./	to the cause of death?
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ည်	law ras be	Completed	<u>Alzheimi</u>	ers Typ)e_	Der	nen	tea			24a. Was auto	DSV	_ prior to	utopsy findings available completion of cause of
VIGIL	Attending Physician: The laving death. sr death. rector: After this certificate has by the funeral director, page 2			<u> </u>							1 Yes	2 No	death? 1 ☐ Ye	
<u> </u>	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Dutpatier	, a = 20	Dthe		-	(Check only o		6 □Other (Sp	
õ	g Phy er this eral d	-	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o		Bc. Injury Work			28d. Describe			өспу)
Vision	ath. rr: Aft	atio	1	on	y 1 667)	fnjury	М		es 2 🗆 1	No				
<u> </u>	r Atte	Certification:	3 Suicide 6 Could not determine		ury - At ho	ome, farm, str	eet, factory,	office			28f. Location (City or To			Rural Route Number,
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	Hosi 24 ho Fun etely f	Medicai	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medicel Exi	Physicien: To the best aminer: On the basis of and manner sta	examina	tion and/or in	n occurred a vestigation,	it the time in my opi	e, date and inion, deat	d place, th occurr	and due to the ed at the time,	date and) and manner a d place, and du	is stated. le to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification the Funeral Director. It is the funeral director.	Me	29b. Signature and title of certifier	٦,			29c.	License	number			29d. Da	te signed (Mor	oth, Dey, Year)
	^		1/1/5	CA-		-	1	100	54:	337	•			
	(h)		30. Name and address of person wh				Print)							
			Dr. Richard	Stetano	ICCI	freels?	250	STON	2+111	60	de Ct	W	loadbin	emd 21797
*	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2005	Survey S	Fo Sign	1000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ^{Day} 2005 Month Richard L. O'Brien Year April /Medical 7:45 A 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richie Hospice Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours XXM 2□F Min 72 Yrs. 219-30-8950 Director 1933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked othar than "natural", or Itams 23a or 28a-f show traumatic avant, I'm Medical Exantrier myst be notified at 10d. Inside City Limits Maryland N/A**Funeral Director** Baltimore 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1337 Roland Heights 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates:Korea 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Be Completed by 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 8th Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic av onte. James Henry O'Brien Retta Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael O'Brien (Son) 1337 Roland Heights Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State ` 4 □ Donation 5 □ Other (Specify) National Crematory 4/19/2005 Alexandria, Virginia 21. Signatur of Funeral Se /io- Li / nsee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Immediate Cause (Final Burgee-Henss-Seitz Funeral Home, Inc. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METAS 54SES 18 MEDIASINUM /Medical Due to (or as a consequence of): **Examiner** of leen Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due o (or as a nsequence The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 1 Yes 2. No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No : After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Tyes 2 No Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760, Division of Vital To the Hospital or Attanding Physician: within 24 hours a To the Funeral I

41.7/05 at

TXPIRED

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Tryes, ms) / who in who completed cause of death (Item 23a) (Type, Print) 827 LINDEN AVE. 21701 AYES 31. Date filed (Month, Day, Year)

State Registrar

Medical

APR 19 2005

			1 - For Stete Registrar	State of Maryla		artment rtificate			nd Men		iene	005	13208
	Physici	25	1. Decedent's Name (First, Middle, Las	")						Date of Deat	n Day	Year	3. Time of Death
	/Medio		JOSEPH F. PRESHO	OOT						PRIL 1			1105 P M
}	Examir		4a. Facility Name (If not institution, give			4b. City, T	own, or L	ocation of	Death		4c. Cou	inty of Death	1
			LAUREL REGIONAL I			LAU					PRI	NCE G	EORGES
	Funeral Director		5. Social Security Number 6. Se 106.14.2887	x	last birthday) Yrs.	If Under		Hours	Min.	Date of Birth Month, Day, CT 5,		9. Birth	nplace (State or Foreign untry) NY
	show		10a. State 10b. County	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Mary L sh	ğ	MD HOWARD	177	የርጥ 17D T	EMTACIT.	TD						1 Tyes 2 No
	1 the	Director	10e. Street and Number	W.	EST FRI	10f. Zip (10	Og. Citizen	of What Co	
	38 o		2603 WELLWORTH WA	ΛY		21	794					USA	
	72 hours after death with the Maryland Insturel', or Items 23e or 28e-f show diest Exantrer must be Lottified at	Funeral	11. Marital Status	12. Was Decedent Ever in U		Was Decede	ent of Hisp	panic Origi	in? (Specify	Yes or No-	14. F	Race - Amei	
စ္	after dea or Items infree m		1 Never Married 2 Married	Armed Forces? 1XXYes 2 □ No If Yes, Give		_			Puerto Rica	n, etc.)		Black, White	o, etc.
8	irel',	d by	3 Vidowed 4 □ Divorced	Year or Dates:		1□Yes 2	XX_	Specify:			Spe	wH.	ITE
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Maryland 21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use	,						
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an	ld be ental ked o	00	KARL PRESHOOT						Y DITC		ardon Can	iamo)	
<u></u>	2 should be and Mental le marked eumetic ev	2	19a. Informant's Name/Relationship (T	γρe, Print)	19b. Mailir	a Address	Street an		or Rural Ro		City or Tox	wn State Z	in Code)
	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 Ie marked other then "neturel", or Items 23e or 28e -f show other treumetic event. If a Medical Exerciter must be rediffical.		DENNIS R. PRESHOO	T					WEST		-		
Jre,	s 1 a	3	20a. Method of Disposition	20b.	Place of Dispo	sition (Name	e of	Ĭ	Date		Oc. Location	on - City or T	own, State
E	Page nent c		1 ☐ Burial 2 ☐ Fremation 3 ☐ Contact of Con	Removal from State D.	TOKEN	CORP	ioi piaco,	4	.19.20	005 T	DNAWA	NDA, I	ΝY
Baltimore,	permit. Pages Department of h Importent: If ite eny injury or of		21. Signature of Funeral Service Licent		F	. Name and INK FU	JNERA	T HO	ME, P. W GLEN	A.	re w	2104	:1
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	/Medical		resulting in death)	a ASP Due to (or as a consec	TRATION quence of):	N PNEU	IMONT	Α				-	3 HOURS
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	and trans	Examine		c.									
8760,	cate be executed physician and the burial-transit	E		Due to (or as a consec	quence or):								
87	physic the l	Completed by Physician/Medical	•	d									
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Вох	atten for u	cian	in the past 12 months?	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a	al death 3	Ectopic pre						Date of deliv Month	rery Day Year
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Q	The law requires that the tte has been signed by th page 2 should be detache	y Pt	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cau	use given	in Part I.	:	23e. Did tob	acco use co	ontribute to	the cause of death?
rds,	n sign	q p	CEREBROVASCULAR	ACCIDENT						1 🗌 Ye		3 ☐ Pro	babiy 4 Unknown
Vital Record	s been si should	iete	DIABETES							24a. Was an	XX	b. Were aut	opsy findings available
æ	The lav te has age 2	mo	DIRBUILD				-			autopsy perferre		prior to co death?	ompletion of cause of
ta	en: tifica tor, p	0	25. Was case referred to medical				2	6 Place o	of Death (Che			1 🗆 Yes	2□ No
<u> </u>	Physicien: The la r this certificate ha. ral director, page 2	To B	examiner?	lospital:	ER/Outpatien	3 DOA	Other		ing Home			Other /Speci	fv)
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Division of	or Attending after death. Director: After in by the funer	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	et, factory,	office			ocation (Stre		mber or Rur	al Route Number,
ā	itel or / rs after el Dire	Certification:											
	To the Hospitel or Attending Ph Within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) XXX Certifying Phy 2 Medicel Exami	sicien: To the best of my knoner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at estigation, in	the time, n my opin	date and j	place, and d occurred at	ue to the car the time, da	use(s) and e and place	manner as s e, and due t	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	-		29c.	License n	umber		29	d. Date sigi	ned (Month,	Day, Year)
	- s + ō		Andre L	endert		DO	0367	16			4.13.		
	67		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type, I	Print)							
_/	2		ANDREW KURDOUT, M.	D. 8317 CHERY	LANÉ I	AUREL	, MD						
*,e	Sta Registr	83.5	31. Date filed (Month, Day, Year). APR 1 9 20	32 degistrar's Signa	ature do	who							

			_ State	of Maryland / Departmen	t of Health and Mei e of Death		_000	13209
			1. Decedent's Name (First, Middle, Last)	Continuati		Reg. N Date of Death		3. Time of Death
1	Physici /Medic		Veronick Dr.	CE	Д	Month D	13 2005	-1215 PM
	Examir	er	4a. Facility Name (If not institution, give street and	number) 4b. City,	Town, or Location of Death	- /	tc. County of Death	, /
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under		Date of Birth	9. Birth	place (State or Foreign
	Director	0	214 243542 10M 3XF	G7 Yrs. Months	Days Hours Min.	(Month, Day, Yea	107 BA	HMORE
	yland low		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
	e Man	ctor	Maryland N/A	BALTIMORE	CITY			1 ⊠Yes 2 □ No
	with th	Director	10e. Street and Number	10f. Zip		10g. (Citizen of What Cou	intry?
	death with the Maryland rms 23e or 28e-f ehow rmat be rotified	Funeral			1205 dent of Hispanic Origin? (Specify	Yes or No-	14. Race - Amer	ican Indian,
9	or Ite		1 Never Married 2 Married 1 Yes	s 2.1XTNo	lent of Hispanic Origin? (Specify offy Cuban, Mexican, Puerto Ric 2 🗹 No Specify:	an, etc.)	Black, White	, etc.
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 ehow any injury or other traumatic avent, it is Medical Examiner must be routilled at once.) Be	17. Father's Name (First, Middle, Last) CNKNC	200	18. Mother's Name (F	irst, Middle, Maide	ən Sumame) ひん	KNOWA
ary	should and Me a mark umatio	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address	(Street and Number or Rural R	oute Number, City	or Town, State, Zi	p Code)
	1 and 2 Health a em 27 is		DOROTHY GILMORE			ALTIMO	RE, MD	21205
ore	ges 1 it of H if iter or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from the second sec		ther place)		Location - City or T	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee	BALTIMORE NATIO				MARYLAND
Ba	permit. Departr Imports any inji		Dietrich N.W	Illiams JOSEPH	d Address of Facility H. BROWN 3 FULTON AVE. BY	R. FUNEI	RAL HON EMARYLAN	NE VD 21217
The state of			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	t caused the death. Do not enter the mode	e of dying, such as cardiac or re	spiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	and Streng	Hementrin			Onset and Death
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	7	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	o (or as a consequence of):				
Q.	and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):				
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical E	d	J (of as a consequence of).				
9	tificate ng phy as the	Medic	0.					
Вох	eath certific attending p	lan/N	in the past 12 morths?	outcome of pregnancy b birth 2 Fetal death 3 Ectopic pre			23d. Date of deliv	Pery Day Year
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٩	ires that signed by the deta		Part II. Other significant conditions contributing to	death but not resulting in the underlying ca	ause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ord	w require been sig should b	ted t	- litype to	ujion		1 🗆 Yes	2 Pro 3 □ Pro	bably 4 [Unknown
Records,	has be	Completed by	•			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vital F	Th ate pag	e Co	25. Was case referred to medical		00 51	1 Yes 2 N		2 🗆 No
f Vi		To B	examiner?	☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	26. Place of Death (C A Other: 4 Jursing Home		6 ☐Other (Speci	fy)
n of	iing Pt J. After th funeral	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending (M		Bc. Injury at 28d. Work?	Describe how inj		
Division	Attending r death. actor: After by the fune	licati	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At home, farm, street, factory,	1 Yes 2 No	Location (Street	and Number or Run	al Route Number
Div	el or A s after il Dira	Certification:	4 Homicide determined bu	Iding, etc. (Specify)	, onles	City or Town, Sta	te)	ar riodio reambor,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical ((Check only 2 Medical Examiner: On the	he best of my knowledge, death occurred a basis of examination and/or investigation,	at the time, date and place, and in my opinion, death occurred a	due to the cause(s) and manner as s	stated.
	o the lithin 2, o the lo the lo the lomplet	Med	one) and m 29b. Signature and title of certifier	anner stated.	. License number		ate signed (Month,	
	F 3 F 8) Ag	MS				
	1/		30. Name and address of person who completed ca	use of death (Item 23a) (Type, Print)	D27569 338 Green	_	0.	>
	- 01		31. Date filed (Month, Day, Year)	Hegistrar's Signature	138 Gleen	e / ree	blo	41208
	Sta Registr		APR 1 9 2005	we & Spelle				

05-02399 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jevonte Philpot 1- State of Maryland Department of Health and Mental Hygiene 15 State of Maryland Department of Health and Mental Hygiene 15 State of Death **RJD** 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 5, 2005 **Physician** Year 1810P. Jevonte Philpot /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner W/B Suitland Pkwy. and Meadowview Dr. Prince Georges Suitland 8. Date of Birth (Month, Day, Year)
July 3, 19 6. Sex 1 XM 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. Director 577-98-0468 26 Washington, 1978 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City Town or Location show 10d. Inside City Limits l Hygiene. othar than *natural; or Itams 23a or 28a-f shov rant, Ita Medical Examinar must be codified at 1 XYes 2 No Director Prince Georges <u>Forestville</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3710 Walters Lane 20747 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes WNo If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XXNever Married 2 ☐ Married 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Football Coach **EDU** .. Pages 1 and 2 should ba filed v tment of Health and Mental Hygie tant: If itam 27 is markad othar t jury or othar traumatic avant. In 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Philpot Ceasar Dorothy Brown ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 Walters Lane, Forestville, N. 20747
ace of Disposition (Name of Date 20c. Location - City or Town, State Dorothy Brown/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Resurrection Cemetery April 15,05 Clinton, MD 22. Name and Address of Facility
Austin Royster Funeral Home
8821 14th St., N.W., Washington, DC 20011
Approximate Interval Between Onset and Death 21. Signature of Funeral Service Licensee 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or feart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, any, leading to min-ediats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Completed page 2 s or Attanding Physician: funeral director, Be after death. in by the

filled within 24 hours a

completely

Medical

Baltimore, Maryland 21215-0036

Box 68760,

of Vital Records, P.O.

Division

Certification: To 29a. Certifier

25. Was case referred to medical examiner? 1X Yes 2 □ No 27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) (Scene)

28a. Date of Injury Found 4/5/5 Found 16:00M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 No 28d. Describe how injury occurred that went off road, overturned into creek 28f. Location (Street and Number or Rural Route Number City or Town, State) CYCLK WEYT TO WIB M

check Suitland Prwy @ Wes downtow Dr. 1500 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed caus

29c. License number OCME

111 Penn Street

29d. Date signed (Month, Day, Year) April 5, 2005

Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State

32. Registrar's Signature APR 1 9 2005 S. Company

Registrar

of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 15 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16, 2005 **Physician** Truman Francis Painton 10:32 a M /Medical 4a. Facility Name (If not institution, give street and number) 207 Kings Crossing Circle, 4b. City, Town, or Location of Death 4c. County of Death Examiner Unit 3A Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 941 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex Funeral 1 ☐ M 2 ☐ F Canada Director 108-32-0041 64 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. Its Modical Examinar must be notified at Bel Air Harford 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 U.S.A. 207 Kings Crossing Circle, Unit 3A death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 Yes, Give ear or Dates: 1 ☐ Yes 2☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene (important: if item 27 is marked other than any injury or other traumatic never Elementary/Secondary (0-12) Colfege (1-4or 5+) health care adm. executive director 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Gelinas Truman William Painton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Kings Crossing Circle, Unit 3A, Bel Air, Md. Crystal Painton/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/2005 Baltimore, Md. * 4 □ Donation 5 □ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. fmmediate Cause (Final Acute Myocardia Sccouds **Physician** resulting in death) /Medical Due to (or as e consequence of) Examiner Idio yeurs pathi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetel death in the past 12 months? Month Day Year 4☐Pregnant at time of deeth 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D34652 no completed cause of death (ftem 23a) (Type, Print) 10 Avenue Bol Air Maryland 2 North 31. Date fifed (Month, Day, Year) 32. Registrar's Signature Registrar

Physician

Funeral

Director

itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic evant. The Madical Examples in its less redified at

1 - For State Ragistrar

1. Decedent's Name (First, Middle, Last)

EUGENE J. PAPIRI

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permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is rr any injury or other traum once.

To Be C	25. Was case referred to medical examiner? 1 Tyes 2 Tyo	Hospital:	Other	eath (Check only one) Home 5 Residence 6 Other (Specify)
atlon:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	g (Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ		home, farm, street, factory, office cify)	28f. Location (Street and Number or Rural Rou City or Town, State)
edical (29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best of my k Examiner: On the basis of exami and manner stated.	nowledge, death occurred at the time, date and plac nation and/or investigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated curred at the time, date and place, and due to the
Me	29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day,
	Sings	MD	RES 000	4.15.200
	30. Name and address of person	who completed cause of death (It		ch Raven Blvd. Balto.

/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE, MD GOOD SAMARITAN HOSPITAL, BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days **№** M 2 F Yrs. 218-18-8235 12/9/1925 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE PARKVILLE 1 ☐ Yes 2 ☐ XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1805 DALHOUSIE COURT 21234 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: WWII 1 Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER HOTEL 11TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VINCENT PAPIRI JOSEPHINE CONSTANTINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH A. PAPIRI/BROTHER 8126 OAKLEIGH ROAD BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State NEW CATHEDRAL CEM. 4/19/2005 BALTIMORE, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Heath Har 8521 LOCH RAVEN BLVD. TOWSON, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VENTRICULAR PIBRILLATION disease or condition resulting in death) Due to (or as a consequence of): THEROSCIEROTIC CVO/CARDIOVASCULARDISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus 1 Yes 2 No 3 Probably 4 Junknown ompleted PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 110 1 Yes 5 Residence 6 Other (Specify) d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rag. No.

Day

15

Year

2005

Location (Street and Number or Rural Route Number, City or Town, State)

at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 4.15.2005 Raven Blvd. Balto. MD 21239 BALTIMORE, MD

3. Time of Death

4:45 PM

2. Date of Death

Month

04

31. Date filed (Month, Day, Year) 32. Registar's Signature Blown I. APR 1 9 2005

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For Stata Ragistras Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician APRIL 7:40 A M 2005 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** HOSPICE CHRIST 1 OUSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth

House Min (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 20.36.7388 1□M 20 F Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at ACTIMORE 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A or Items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) HEALTH CARE ADMINISTRATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fii h and Mental H 7 Is marked otl permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked eny injury or other traumatic ewones. KEBECCA 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) DEANWOOD PACTIMORE, MD 21234 DAVGHTER KOAD 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State ABERDEEN, MAKYLAND MEMORIA GARDENS 4 Donation 5 Other (Specify) 22. Name and Address of Facility VA 4105 York ROAD 21. Signature of Funeral Service Licensee Drive Vander BAUTIMORE, NO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COMCOZ ovarian years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental forms of the cause fundamental fundamental forms of the cause fundamental f Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 si 2□ No 1 TYes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 0 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Medical Certification: 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D Completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 1º.9°2005

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ON Charles No letter No Charles St Baltwore Mo

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	Physic /Med		1. Decedent's Name (First, Middle, Last) Guido A. Paz-Guevara		2. Date of Death	Day Year	3. Time of Death $10:47 \ \text{P}^{\text{M}}$
	Exami Funeral Director	ner	4a. Facility Name (If not institution, give street and number) Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219-68-1972 1 ★ 2□ F 65 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Mont go	OMETY blace (State or Foreign
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		SEP 8, 19		IVIa Od. Inside City Limits
	th the Mar or 28e-f st	Director	Maryland Montgomery 10e. Street and Number	Silver Spring		Citizen of What Cour	1 □Yes 2X No
	laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-1 show eumatic avant, the Medical Even invertinest the redition	Funeral D	2105 Westview Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Marital Status	20910 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White,	
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	and and lealth m 27 her tr		Aldo T. Paz-Guevara, M.D./Brother 3 20a. Method of Disposition 20b. Place of Disp	ing Address (Street and Number or Rural 10 Valley Court Roa cosition (Name of practice)	ad Lutherv		21093
<u>:</u>	Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		`4 □Donation 5 □Other (Specify) Metro Cre	ematory, Inc. 4/15 2. Name and Address of Facility Cremation Society of 299 Frederick Road		Baltimore,	MD
•	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of):	299 Frederick Road Iter the mode of dying, such as cardiac or	Baltimore respiratory arrest.	e, MD 2122	Approximate Interval Between Onset and Death Weeks
22.47 pm	icate be executed by physician and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last b. As iration Properties (Due to (or as a consequence of): c. Due to (or as a consequence of):	neumonia			2 Weeks
at	D. BOX of the death certification the attending the death of the asset as	Completed by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
114/05	vequires that the second by should be detacted by	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the u $Cirrhosis$	inderlying cause given in Part I.		use contribute to the	
7	The law recale has bee	Complete	Acute Renal Failure		24a. Was an autopsy performed?	24b. Were autop prior to comdeath?	esy findings available apletion of cause of
2	OI VIIGH Physician: The Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Impatient 2 □ ER/Quipatient	26. Place of Death			
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12,6	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, ste building, etc. (Specify)		Bf. Location (Street a City or Town, Star	te)	
PA	na Hosp 24 hoi ne Fune bletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the cause(: d at the time, date ar	s) and manner as sta nd place, and due to	ited. the cause(s)
•	Totl withii Totl	W	29b. Signature and title of certifier MCMOMMD.	29c. License number D0061631	29d. D	ate signed (Month, D 4-15-0	
	Y		30. Name and address of person who completed cause of death (Item 23a) (Type. Natasha Chen, M.D., 8600 Old	,	l, Bethe	sda, MD	20814
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 1 9 2005	heath ?			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day QUEEN Physician Month Year GENILA 5.03 AM APRIL 2005 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NIA THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months Days Hours 376.32.7209 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, Ite Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD ANNE ARUNDEL CROWNSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CHAPEL ROAD USA 1629 SEVERN 21032 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) REAL ESTATE SPECIAUST FEDEAD) GOVI. 12/11 GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H Be JERALD LAWRENCE BRYANT ШLA ٩ . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 1629 SEVERN CHAPEL RD., CROWNSVILLE IMD 21032 1HEODORE QUEEN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition jo # ō 1 KBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 04.21.05 BALTO. MD LOUDON PARK ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATI PIKE BALTO. MD aus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years CANCER 70 LUNGS METASTATIC COLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclan use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 3 been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 2 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Sinpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number MD P17600 ARIL 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 THE JOHNS HOPKINS MOSPITAL, 600 N. WOLFE ST. BALTIMORE-MA BINIRUPAMA D. MITIKIRI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Here It Speaks

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland	I / Department of F Certificate of		ntal Hygiene Reg. No	.000 10610
}	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) James D. 4a. Facility Name (If not institution, give s	RIDING G			Date of Death Month Da PRiL 13	y Year 3. Time of Death 3 40 PM.
	Funeral Director		5Tella Man is 5. Social Security Number 6. Sex 175-40-1298 1 Usual Residence of Decedent	HOSPICE 7. Age (In yrs. Ia M2DF 55		Hours Min.	Date of Birth (Month, Day, Year)	BALTIMUILE 9. Birthplace (State or Foreign Country) PA
	after death with the Maryland or items 23e or 28e-f show	Director	10a. State 10b. County BAL	Timore 10c. City,	Town or Location PARK	ville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 236 or 2		10e. Street and Number		10f. Zip Code	21234		tizen of What Country? U 、 ろ ・ A ・
980	72 hours after death with the Maryland neturel; or items 23s or 28s-f show ites! Everhartmust be routh, a st	by Funeral	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No U.S If Yes, Give Year or Dates: AR	5. 1□Yes 2□No	dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: Loh (Te
21215-0036	within 308. then "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire.	during most of working d)		ind of Business/Industry
Maryland 2	S should be filed and Mental Hygie is marked other sumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) HARRY R. DIN	6 er		18. Mother's Name (F	First, Middle, Maider Unt.กณ	n Sumame)
	S as as		BONNIE RIDING	er (wife)	19b. Mailing Address (Street	ior Ave B.		
altimore,	90=5		20a. Method of Disposition 1 ourial 2 Cremation 3 F 4 Donation 5 Other (Specify)	ionioval iloni otato	ace of Disposition (Name of metery, crematory or other plance)	71.01		ocation - City or Town, State
Balti	permit. Pag Department importent: I eny injury o		21. Shinature of Funeral Service Licens		22. Name and Addre HARTLEY M 7527 has	iss of Facility STellinger STellinger RD.	A FUNEER BAlito. N	of 21234
	Physician /Medical Examiner	ıer	if any, leading to immediate	ications that caused the death. ne cause on each line. LUNG CANCER Due to (or as a consequence). Due to (or as a consequence).	ence of):	ng, such as cardiac or r	espiratory arrest,	Approximate Interval Batween Onset and Death
8760,	ate be executed obysician and the burial-transit	Ical Examin	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequent.	ence of):			
O. Box 6	The law requires that the death certificate be executed at the been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of the pregnant at time of de go Unknown	death 3 □Ectopic pregnanc	у		23d. Date of delivery Month Day Year
ds, P.	uires Ihat i signed b id be deta	by	Part II. Other significant conditions con	ntributing to death but not resul	lting in the underlying cause gr	ven in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
al Records,		Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \] 2 \[\text{No} \]
n of Vital	To the Hospital or Attending Physicien: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	on; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📆 No 27. Manner of Death 1 📆 Natural 5 ☐ Pending		ER/Outpatient 3 DOA Ott	ry at 280		6 X Other (Specify) HOSPICE any occurred
Division	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory, office]Yes 2 □ No 281	f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical (sicien: To the best of my knowner: On the basis of examinati and manner stated.				s) and manner as stated. Id place, and due to the cause(s)
)	within comp	Me	29b. Signature and little of certifier		29c. Licen:	725	29d. Da	ate signed (Month, Day, Year)
	,7,		30. Name and address of person who co		23a) (Type, Print) Y VALLEY RD.	TIMONIUM,	MD 21093	,
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 9 20	32. Begistrar's Signat	ure			

DHMH 17 Rev 1/2001

APRIL 13, 2005

JAMES RIDINGER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 47 AM Oger 1 200 INIC /Medical 4a. Facility Name (Inot institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Barriew Medical Center Balt onns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 ☐ M 2 🕱 F 225-14-6990 Virginia Yrs. 88 June22,1916 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 X No Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Ave. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify:White Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carville Wilson Annie R. Lerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Davies/daughter 9929 Philadelphia Road Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oak LawnCemetery 4/16/05 Baltimore MD 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licenses onn 300 Mace Ave. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 50 days Due to (or as consequence of): Weet Tract Sequentially list conditions, any landing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a con equence of): Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy le 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2× No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Enysician /Medical Examiner

permit. Pages Department of Important: If it any injury or c

Funeral

Director

item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours affer inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturel", or Ite

Saltimore, Maryland 21215-0036

the Maryland

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death

The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans use detached for þ signed should be page 2 has or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

filled in by the funeral dir Certification: within 24 hours a To the Funeral L

3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Medical

State Registrar

completely

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License numbe

HVenve

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital

B	,097
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	P.O. B
	Il Records, P.O. Box 68760,
	ital Re
	of Vita
	Division

				Please 1	Type or Prir	nt in Bla	ack In	delible	e Ink.	Ensure	All Copies	Are	Legible.	
			For State Registrar		State of Ma	aryland	•	artmen rtificat			Mental Hy	giene Reg. No.	000	13218
	Physicia			e (First, Middle, Last BERTHA)			RUBEN	ISTEI	N	2. Date of De Month April			3. Time of Death
П	/Medic Examin		4a. Facility Name (I	If not institution, give		nore		4b. City,		Location of De	ath 174	4c.	County of Deat	N/A
	Funeral Director		5. Social Security N	lumber 6. Se		e (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours Mi		rth ay, Year) 1913	9. Birt	hplace (State or Foreign untry) MD
puland	show		Usual Residence of 10a. State	10b. County		10c. City,								10d. Inside City Limits
th the Ma	or 28a-f s	Director	MD 10e. Street and Nu	M/A mber			BALT	I MO RE				10g. Citi	izen of What Co	
d 21215-0036 filed within 72 hours after death with the Maryland	or Items 23e	5833 PARK HEIGHTS AVENUE 21215 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto If Yes, Give 1 Yes 20 No Specify:									(Specify Yes or No erto Rican, etc.)			
5-0036	"neturel",	eted by		4 □ Divorced 15. Decedent's Educify only highest grad	Year or Dates:		16a. Dece	dent's Usua kind of wo	al Occup	ation during most of v	vorking	16b. Ki	ind of Business/	WHITE
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Maryland 21	e da la S	To Be	ABRAHAN	(First, Middle, Last)			WILL	IAMS		FANN I	lame (First, Middle E	a, Maiden	Sumame)	TUROW
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altimore,	D C			position Cremation 3 5 Other (Specify)		cen	ce of Disponence	matory or c	other plac		Date 4/18/20		BALTIM	Town, State ORE, MD
Baltin	Department Importent: I Importent: I eny injury o			uneral Service Licens		0.1.0.2	22	2. Name ar	nd Addre	ss of Facility	OL LEVIN	ISON .	& BROS.	
P	hysician		shock, or hea	the disease, or comp art failure. List only of (Final	lications that caused ne cause on each li	ne.							SVILLE,	Approximate Interval Between Onset and Death
	/Medical xaminer		disease or condition resulting in death)		Due to (or as	a conseque		ttici	le	colin	H's			7 days
760,	physician and s the burial-transit	sal Examiner	Sequentially list or if any leading to if cause. Enter Und Cause (Disease of that initiated event resulting in death)	erlying r injury s Last	Due to (or as Due to (or as d.									
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rds, P.	n signed build be deta	by	Part II. Other signi	ificant conditions co	ntributing to death b	out not resulti	ing in the u	ndertying o	cause giv	en in Part I.		tobacco u		the cause of death?
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	ysicient.	o Be	25. Was case refe examiner? 1 Yes 2		Hospital: 1 Nopatio	ent 2∏E	R/Outpatier	nt 3□ D0	Oth	or:	Death (Check only) Thomas 5 Res		6 Other (Sae	C(fu)
Division of	= 6	-	27. Manner of Dea		28a. Date of Inju (Month, Da		8b. Time o Injury		28c. Injur Wor		28d. Describe			
Divis	after death. I Director: After d in by the funer	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place of In	jury - At hom tc. <i>(Specify)</i>	ie, farm, sti	reet, factor	y, office			(Street an own, State		ural Route Number,
2	within 24 hours after To the Funerel Director Completely filled in by	edical (29a. Certifier (Check only one)		rsician: To the best iner: On the basis of and manner st	f examinatio								
) 	withir To th	Me	29b. Signature and	1111	edical D	octor		29	c. Licens	e number			te signed (Mont	
	3		VISHMUPR	Iress of person who o	ANE 240	1 West	- Bei	Print) vede)	re t	luenue	Bultimo	ove	MD 21	215
	Sta Regist		31. Date filed (Mg	TPR"1"9" 200	3 Regist	rar's Signatu	re							

Toshua Snodgrass 05-2682 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5

13219

		•	1 - State Registrar			,	Cei	rtificate	of D	eath		Reg. N	. O O O	ŧ	0 = 1 -
	Dhusisi		1. Decedent's Name (Fi	rst, Middle, Las	t)	•					2. Date of I		ay Ye	ar	3. Time of Death
	Physici /Medic		JOSHUA		SNODGRASS						April		2005		4:40 P M
	Examin	er	4a. Facility Name (If not)		4b. City, To	own, or Lo	ocation of Dea	ith	4	c. County of I	Deeth	
			1121 Tippe			(1 (-	and beliefe after 1	Clinto		f Under 24 Hr	s l s 5	P	rince	Geor	ge's
	Funeral Director		5. Social Security Numb 005.88.9894 Usual Residence of Dec	4 1	M 2 F	ge (In yrs. las	Yrs.			Hours Mir				Country	ce (State or Foreign y) TLAND
	ow ow			b. County ·		10c. City,	Town or Lo	cation						100	1. Inside City Limits
	death with the Maryland ms 23a or 28a-f show fritted be notified at	tor	MD DI	TNCE C	FODCEC	CAM	IP SPR	TNCC							1 ☐ Yes 2☐ No
	r 288	Director	MD PI 10e. Street and Number	RINCE G	EUKGES	CAP	IL SIN	10f. Zip C	ode			10g. C	itizen of Wha	t Country	
	h with		2128-E RICE	HMOND DI	RIVE. AND	REWS A	FB	20	0762				USA		
		Funerai	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.		Was Decede	nt of Hisp	anic Origin? (Mexican, Pue	Specify Yes or I	No-	14. Race -	American Vhite, etc	
Maryland 21215-0036	within 72 hours after ene. than "natural", or ite ts Midical Examina	þ	1 weer Married 3 Widowed 4 □		1 ☐ Yes 2 X If Yes, Give Year or Dates:			1 ☐ Yes X		Specify:			Specify:	WHIT	
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and	be fi	Be	17. Father's Name (Firs								ime (First, Midd		in Sumame)		
\ <u>₹</u>	should and Men s marke umatic	ဥ	KEVIN SNODO		5 D		405 14-18-				L. ANDE		T 0	. 7. 0	
	ages 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene. I: if item 27 is marked other than "natural or other traumatic event, If a Medical E.		19a. Informant's Name/ KEVIN SNODO	GRASS	урв, Print)		2128-	E RICI	HOND		AMP SPR	INGS	, MD 2	0762	
ore	of Hi of Hi ff iter		20a. Method of Disposit		Removal from State		ice of Dispo metery, cren	sition (Name natory or oth	of er place)	i	Date	20c.	Location - Cit	or Tow	n, State
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Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature pi Funera	Il Service Liven	FINK	MO1148					SUPPOR GLEN BU		.MD 210	061	
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9 X	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit		IF FEMALE:		23c. If yes, outcome	of program	01/				1577			54	
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	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unknown	it time of dea	X(II J _	_ Other (spec	, ny)						
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of	ding Phone.	Ë	27. Manner of Death	-	28a. Date of Inj (Month, D.	ury 2	28b. Time of Injury	-	c. Injury at Work?		28d. Describ				Ob secr
Division		Certification:	1 □ Natural 5 2 □ Accident	Pending investigation	and the second		16:15	0 M	1 Te	2 6 No	PASSEN	kn I	LACA	250	were KIYED
V:S	i or Atteni after deati Director:	tific	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of In	jury - At hom	ne, farm, str	eet, factory,	office		28f. Location	(Street a	and Number o	r Rural F	Route Number, UD
Ö	telon rsatt at Di	Cer				01 Du					MUTI	RETT	PD C4	MON	P. Georgia
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medicai	29a. Certifier 1 ☐ (Check only one)	Certifying Phy Medical Exam	ysicien: To the best liner: On the basis and manner s	of examination	ledge, death on and/or in	n occurred at vestigation, it	the time, n my opin	date and place ion, death occ	e, and due to the curred at the time	e cause(e, date a	s) and manne nd place, and	r as state due to th	ed. ne cause(s)
	To the within To the comp	N	29b. Signature and title	of certifier					License n	umber		29d. D	ate signed (N	onth, Da	y, Year)
	1		▶ May	Free Mh	elffull	h	1M	O	CME			I	April 1	.7, 2	2005
_	100		30. Name and address	of person who	completed cause of	death (Item 2	23a) (Type,		1.0						
	V		MARYDRI	DD D	KOREL			1	II P∈	enn Str	eet Ba	1tim	ore, M	ary1	and 21201
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental HygieRe Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 04-Year 05 9:4/4 9M Eula Mary Schimunek 15 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Rosedak If Under 1 Year | If Under 24 Hrs. Franklin Square Center Baltimore Huspital Social Security Number 8. Date of Birth (Month, Day, Year) May 16, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1 ☐ M 2 👿 F 94 Yrs. 220-46-8652 Maryland 1910 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maruland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 Chesapeake Avenue 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Walter Marousek Catherine Era 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan Schendel 1400 Chesapeake Ave., Middle River, MD 21220 (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Most Holy Redeemer 4/18/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21220 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis

Due to (or la consequence of): day Heart Failure ongestive Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2/2/No 1 Tyes 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner The law requires that the death certificate be executed

once

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercises in an installed recipied at

permit, Pages 1 and 2 should be file Department of Health and Mental Hyy important: If item 27 is marked other any injury or other transment.

filed within 72 hours after death

 $\mathcal{QCh}(m_{HR}, k_{e}, k_{e}, k_{e}, k_{e})$ Baltimore, Maryland 21215-0036

burial-t the attending physician the as 9Sn ō detached ģ **pe** peen certificate has page 2 this

funeral After death. the filled in by

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending within 24 hours after deatl To the Funeral Director: completely 20 State

30. Name and address

Dr. Kamlun 31. Date filed (Month, Day, Year)

of person

19

2005

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physiclan/Medical 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 110 1 Dinpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of pertifie

DHMH 17 Rev 1/2001

Registrar

9000 Franklin Square Drive baltimore, Md 21237

who completed cause of geath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** <u> 11:55</u> APRIL 16_ 2005 MARJORIE MICKEY SMITH /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 ☐ M 2 🛛 F 70 Director 01/12/1935 VIRGINIA 219-28-0340 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 ia marked other than "natural", or tiems 23a or 28a-1 ahow other traumatic evant, the Medical Examinat must be notified at 1 TyYes 2 □ No Director MDN/ABALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4107 ROLLINS AVENUE Funeral 21207 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) XNever Married 2 ☐ Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Ā Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHOENIX MANUFACTUR SEAMSTRESS COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h FULTON MICKEY BESSIE PULLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

AVENUE BALTIMORE MD 21207

20c. Location - City or Town, State Pages 1 and 2 ment of Health a DONALD SMITH / SON altimore, 20a. Method of Disposition 1 ☐ Burial 2 Stremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or ö METRÓ CREMATORY 4/19/05 CATONSVILLE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee A 600 LIBERTY HEIGHTS AV. A 600 LIBERTY HEIG 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician weeks XP515 /Medical Due to (or as a consequence of) Examiner 0000 613 Lymphuna Dua to (or as a emasquenes of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknow Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral C completely filled 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

31. Date filed (Month, Day, Year) APR 1 9 2005

AARON CHAMES SID

and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

6601 N. Charles St Balquiore no 21204 Registrar's Signature

APRIL 17 2005

		•	State of M	aryland /	Departme Certifica		ealth and M Death		iene 005	13222
	Dhuaiai		Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day Y <i>e</i> ar	3. Time of Death
	Physicia /Medic		Henry William :		, Jr.			Apr.12	14 2005	2145 M
	Examin		4a. Facility Name (If not institution, give street and number			y, Town, or	Location of Death	•	4c. County of Dea	th
			William Street	tuspita		altim			N/	
п	Funeral		10₹M 2□E	ge (In yrs. last b 87	Yrs. It Und	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign
	Director	-	214-18-1107 Usual Residence of Decedent	0/	113.			JUN 5,	1917 N	Maryland
	land ow		10a. State 10b. County	10c. City, To	wn or Location					10d. Inside City Limits
	Mary f sh	ğ	Maryland N/A			Balt:	imore			t∭Yes 2 ☐ No
	the	rec	10e. Street and Number		10f.	Zip Code	Linole	10	0g. Citizen of What Co	ountry?
	h with	Funeral Director	4503 Frederick Avenue			2122	.9		USA	
	deat	nera	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S.	13. Was De		spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whi	
9	after or ite	교	1 Never Married 2 Married 1 Yes 2 Married	No		2 🔯 No	Specify:	noun, oto.,		
93	urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			21				White
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16	a. Decedent's U (Give kind of	sual Occupa work done o	ation furing most of worki)	ng	16b. Kind of Business	/Industry
121	within ane.	mp	Elementary/Secondary (0-12) College (1-4or	5+)	Floris		,		Flower Sh	qop
	Hygie Hygie ther int.		17. Father's Name (First, Middle, Last)		PIULIS	-	18. Mother's Name	(First, Middle, N	Maiden Sumame)	
anı	d be antal sed o	Be c	Henry William Seamon, S	700				Dietric		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene tems 23s or 28e-f show item 27 is marked other then "naturel", or items 23s or 28e-f show other treumatic event. The Medical Examiner must be notified at	2	19a. Informant's Name/Relationship (Type, Print)		9b. Mailing Addre	ss (Street a			City or Town, State,	Zip Code)
Za	nd 2 s lith ar 27 is 1 treu		Grace M. Seamon/Wife				ck Avenue		nore, MD 2	4.573
ē,	tem 27 tem 27 other tr	1.29	20a. Method of Disposition	0.000.01	of Disposition (f	lame of			20c. Location - City or	
J10			1 ☐ Burial 2 XCremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)	9	-		nc. 4/19	/05	Baltimore	Mil
Baltimore,	그 돈 만 글		21. Signature of Funeral Service Licensee	riecto	22. Name	and Addres	Society (705 E	Darrinore	, MI)
B	Depa Impo any ii		Edward A Gregorchik		299	ition Treder	Society (of MD, I	nc. re, MD 212	220
	0.00		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. De	o not enter the m	ode of dying	g, such as cardiac o	or respiratory arre	est, In 212	Approximate Interval Between
	Physician			E3 PIRAT	over	FALL	1825			Onset and Death Z New TH 5
	/Medical		resulting in death)	s a consequenc						0100111
	Examiner		Convention by the conditions	NEW MOX	UIA					2 HENTHS
	D #	ner	Sequentially list conditions, and leading to mindful cause. Enter Underlying Cause (Disease or injury	s a consequenc	e of					
	nd rransi	Examiner	that initiated events C.	_/-						
Ö,	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or a	s a con equenc	e of):					
8760,	2 2 2	Physician/Medical	d							
9	leath certifica attending ph d for use as th	/Mec	IF FEMALE: 23c. If yes, outcom	a of proppositi					201.01.61	
Вох	attend for us	ian	in the past 12 months?	2 Fetal dea at time of death	th 3 Ectopic	pregnancy			23d. Date of de Month	Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	it time or death	5 🗀 Other	specify)				
P.0	res that the death cer igned by the attendin be detached for use	H.	Part II. Other significant conditions contributing to death	but not resulting	in the underlyin	g cause give	en in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
Records,	uires 1 sign 1d be	Completed by	HyperTENSIEN, Gustroes ophay	eal re	Hux	ancie	mil 1	1 ☐ Ye	s 2□No 3□P	robably 4 Munknown
00	w require been si should I	lete	Ventile In Depondent Colly	Utes A	tru (Mate	tres lea.	24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
Re	he lay e has	mc	Trail and	7001-7 11	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,)	autops	ned? death?	
	iicien: The lav certificate has rector, page 2	e C	25. Was case referred to medical				26. Place of Death			3 2□ No
>	Physicien: r this certifica ral director, i	To B	examiner? 1 Yes 2 No Hospital: 1 Shapat	ient 2 ER/	Outpatient 3	DOA Othe	ar.		ence 6 ☐Other (Spe	ocify)
10	g Ph	n:	27. Manner of Death 1 Natural 5 Pending (Month, D	ury 28t	. Time of Injury	28c. Injury Work	at	28d. Describe ho	w injury occurred	
ior	Attending or death. ector: After by the fune	atic	2 Accident investigation	, , , ,	M		Yes 2 □No			
Division of Vital	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Ir building, a	njury - At home, etc. (Specify)	farm, street, fac	ory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
Q	rel o						1			
	Hosp 4 hou Fune Tely fi	ical	29a. Certifier 1 Certifying Physicien: To the bes 2 Medicel Exeminer: On the basis	of examination a	lge, death occurr and/or investigat	ed at the tim on, in my op	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the tuneral director, page	Medical	one) and manner s 29b. Signature and title of certifier	tated.	,	29c. License	number	25	9d. Date signed (Mon	th, Day, Year)
	F 3 F 8		James F Dan un 1/1	Decide it	lisquel	O.	1346		Alen1 10	2005
	h		30. Name and address of person who completed cause of	death (Item 22)	IT Haves	UU	1770		1 /100 18	ccos
	')		JAMES FLYNN . Mi Versety Sp	righty	Hospital	611 80	writ China	ES BALTI	MINISTE MA	21730
	Sta	te		trar's Signature						
	Registr	ar	APR 1 9 2005	en l	hour	25				

246	9		1 - State Unpend Item 23	State of Ma a,pt.II,	ryland 27 pe	d/Depa e r me e/	rtment o	of Heal	th and N \$thtas	/lental Hy	giene Reg. No	2005	132	223
			Decedent's Name (First, Middle, Last)							2. Date of De	ath		3. Time o	f Death
	Physici /Medic		Louise	A. Surb	er					APRIL	8,	2005 Year	1635	рΜ
	Examin		4a. Fecility Name (If not institution, give str	eet and number)			4b. City, Tov	vn, or Loca	ation of Death		4c	. County of Deat	h	
-			UPPER CHESAPEAKE ME				BELAT					IARFORD		
2	Funeral		5. Social Security Number 6. Sex 1 1 N	7. Age		ast birthday) Yrs.	If Under 1 Y Months D		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da OCT 1	rth ay, Year)	9. Bin	hplace (State ountry)	
	Director		Usual Residence of Decedent		55	113.				001 1	۷, I	949 Mass	sachuse	tts
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside C	City Limits
	a-fst	io	Maryland Harford				F	ores	t Hill				1 ☐ Yes	2 X No
	or 28	lre	10e. Street and Number				10f. Zip Co				10g. Cit	izen of What Co	ountry?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show the Medical Exteril art mart by multified at	Funeral Director	10 Lockhart Circl				210	50				USA		
	er de	nne		. Was Decedent 8 Armed Forces?		6. 13. V	Vas Decedent f Yes, specify	of Hispan Cuban, Me	iic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	0-	 Race - Ame Black, Whit 		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes ZX N If Yes, Give Year or Dates:	О		I□Yes 202	No Sp	ecify:			Specify:	White	
21215-0036	thon atura	edt	15. Decedent's Educa			16a. Deced	ient's Usual O	ccupation		-	16b. K	ind of Business/		
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nd	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Hems 23s or 28s-1 show event, the Medical Existing and nast by nutilised at	Be (17. Father's Name (First, Middle, Last)					18. /		e (First, Middle				
yla	Ment Ment arke	2	Randolph G. Shar							nces L.				
Maryland	12 should be filed within h and Mental Hygiene. 7 le marked other than "traumatic event, the Me.		19a. Informant's Name/Relationship (Type									or Town, State, 2		
	1 and tealt		Daryl E. Surber, .	JI . / SOII	20b. Pl		Daluw_ sition (Name o			u ralls Date		MD 210 ocation - City or		
Baltimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ Rer	noval from State	Ce	metery, cren	natory or other	r place)	1					
Ħ	# # To To To		'4 ☐ Donation '5 ☐ Other (Specify) 21. Signatura of Funeral Service Dicensee	c/	Met	ro Ure	matory	ddress of	Facility	.5/05	Ва	1timore	, MD	
Ba	permi Depa Impo any ir		Edward A Grego	w.		7	Cremati 900 Ero	on So	ociety	of MD,	Inc	MD 212	228	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused	the death							, 110 212	Approxima Interval Bei	te
	Physician		Immediate Cause (Final disease or condition	Atheros		tic co	rdiovo	acul.	or die				Onset and	
	/Medical		resulting in death)	Due to (or as a			TUTOVO	SCUI	ar urse	ease				
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	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	a consequ	ence of):								
(X)	be executed sician and burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a	consequ	ence of):							_	
8760,	cate be executed physician and the burial-transit	dical E												
687	ficate g phys	edic	u.											
Вох	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of			T-+i				}	23d. Date of del	ivery	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 No	1 Live birth			Ectopic pregn Other (s <i>pecit</i>					Month	Day	Year
P.0	at the de by the a stached	Physician/Me	9 □ Unknov√n	9 Unknown										
	The law requires that the death certifi te has been signed by the attending age 2 should be detached for use as	by	Part II. Dther significant conditions controllism Chronic alcoholism	ibuting to death bu	it not resu	Iting in the ur	nderlying caus	e given in	Part I.			use contribute to		
Records,	w requir been si should	Completed								-	Yes 2	UN0 3UP	obably 4 🗍	UNKNOWN
ec	e law has b	nple								24a. Was		prior to	itopsy findings completion of c	
al F							. <u> </u>				2 No	death?	2 No	
Vital		Be	25. Was case referred to medical examiner?	spital:			- X	Othor		h (CHeck only				
of		To :	1 X Yes 2 No No 27. Manner of Death	28a. Date of Injur	у	R/Outpatien 28b. Time of		Injury at Work?	☐ Nursing He	ome 5 ☐ Resi 28d. Describe		6 ☐Other (Spen	city)	
Division	Attanding Phir death. ector: After they the funeral	itlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	м	Work? 1 ☐ Yes	2 🗆 No					
Visi	or Attandi after death. Director: A in by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	iry - At hoi	me, farm, str	eet, factory, of	fice		28f. Location (City or To		d Number or Ru	ral Route Nurr	nber,
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	To the Hospital or Attan. within 24 hours after deat. To the Funeral Director: completely filled in by the	Medical	29a. Certifier Check only 2 Medical Examine	r: On the basis of	f my knov examinati	viedge, death ion and/or inv	occurred at the	he time, da my opinior	ate and place, n, death occur	and due to the red at the time,	cause(s date and) and manner as d place, and due	stated. to the cause(s	s)
	ithin i	Mec	29b. Signature and title of certifier	and manner sta	ieu.		29c. Li	cense nun	nber		29d. Da	te signed (Mont	h, Day, Year)	
	₩ 3 F 8		10011.	Y ~				CME			APRI			
•	VB "		30. Name and address of person who com	pleted ase of de	eath (Item	23a) (Type						سے ور سے ا		
	36		THEODONE Miking					, Bal	timore	, Maryl	and,	21201		
	Sta		31. Date filed (Month, Day, Year)	32. Redistra	r's Signat	ure	-							-
	Registi	ar	APR 1 9 20	INF IF		NI	Lagella D							

Lanita Seidel 05-261 ALG

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	with.	Opening	02.00	

L3			For	State of	of Mai	yland / Dep	artmen	t of H	ealth a	and N	Mental Hy	/gień	è() ()5	132	224
			1 - State Registrar			Ce	rtificate	e of L	Death			Reg. N	0.		4 40 40	2 000
			1. Decedent's Name (First, Middle	e, Last)							2. Date of D Month		ay	V	3. Time	of Death
	Physici /Medio		LaNita G	. Seide	- 1							14,	200	Year 5	5:50) A M
}	Examir		4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death	· · · · · · · · · · · · · · · · · · ·			y of Death		
			1220 East West	Highway	#11	10	Sil	ver	Sprin	ng			Mon	tgome	rv	
	Funeral		5. Social Security Number	6. Sex	_	(In yrs. last birthday	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	irth		9. Birth	place (State	e o <i>r Foreign</i>
	Director		578*20*5571	1□M 2kpF	90) Yrs.	- Wieriano	Dayo	110010		May 22,	1914		Washii	ngton,	DC
	pug *		Usual Residence of Decedent 10a. State 10b. County		- 7	10c. City, Town or L	ocation								10d Inside	City Limits
	sho	5														es 2 No
	28e-f	Director	MD Montgor	nery		Silver Spri						10-0				
	with 1	늅	10e. Street and Number				10f. Zip	Code				10g. C	itizen or	What Cou	ntry?	
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	iten iten	Ë	1 ☐ Never Married 24 Marr	Armed F			If Yes, spec	ify Cuba	n, Mexican	, Puerto	Rican, etc.)			ck, White,		
39	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1 ☐ Yes	2₩ No	Specify:				Speci	^{ty:} Blac	ck	
ŏ	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show fre Medical Exertifier must be notified at	Completed by	15. Deceden	t's Education		16a. Dece	dent's Usua	I Occupa	ition			16b.	Kind of E	Business/In	dustry	
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Maryland 21215-0036	e file al Hy othe vent	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Nam	e (First, Middle	e, <i>Maid</i> e	n Suma	me)		
<u>a</u>	uld b Venti	Tof	Antonio Galo						Mar	garet	Johnso	n				
ar	and Parameters and Parameters		19a. Informant's Name/Relations	hip (Type, Print)			_				al Route Numi		or Town	, State, Zip	Code)	
Σ	and 2 selth n 27 er tr		Vanessa King/ Goo	ldaughter		3311	16th s	st. N	E Wasl	hingt	on, DC 2	0018				
altimore,	of He		20a. Method of Disposition 1-∰Burial 2 ☐ Cremation	3 DRemoval from	State	20b. Place of Disp cemetery, cre	osition (Nan matory or o	ne of ther place	9)		Date	20c. l	Location	- City or To	own, State	
Ĕ	Pag nent ant; i		'4 □Donation 5 □Other (S		State	Ft. Linco	ln Ceme	etery		4/22	/2005	Bre	entwo	od, MD		
at	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumetic event, It a Medical Examiner must be notified at ance.		21. Signature of Funeral Service	Lic see		2	2. Name an	d Addres	s of Facilit	yFt.	Lincoln :	Funer	ral Ho	ome		
<u> </u>	20729		Rechard 1	nompse		3	401 Bla	adensl	ourg Ro	oad	Brentwo	od, M	D 207	722		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the	ne death. Do not er	ter the mod	e of dying	, such as	cardiac	or respiratory	arre <i>s</i> t,			Approxim Interval B	setween
Ľ	Physician		Immediate Cause (Final disease or condition	Smike	and	suct inhe	Jahov	2 600	anlire	Dhe	other	ncal	and	C.	Onset an	d Death
	/Medical		resulting in death)	Due to	(or as a	consequence of):	ce	wdi	ovasc	ula	disea	se	2.1.9.1			
	Examiner		Sequentially list conditions,	b												
7	p iii	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a	consequence of):										
V	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	C	(00.00.0	consequence of):										
8760,	be ex cian ourial	a E	3 ,	Due to	(UI as a	consequence or).										
87	ficate be executed physician and s the burial-transit	dicai		d									-			
×	leath certific attending p		IF FEMALE:	23c. If yes, ou	itcome of	pregnancy							034 D	ato of delia		
a	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	Fetal death 3	☐Ectopic pro☐Other (sp							ate of delivi onth	Біу Day	Year
P.O. Box	the d	ıysic	1 □ Yes 2 🍱 No 9 □ Unknown	9□ Unkr		no or soun	_ O(1161 (3))	ocny)								
<u> </u>	res that the de signed by the a be detached f	y Ph	Part II. Other significent condition	ons contributing to c	eath but	not resulting in the	ınderlying ca	ause give	n in Part I.		23e. Did	tobacco	use con	tribute to t	he cause of	f death?
Division of Vital Records,	uires 1 sigr 1d be	d by									1 🔯	Yes 2	2 🗆 No	3 🗌 Prot	oably 4	Unknown
Õ	w require been si should I	Completed									24a. Was	s an	24h	Were auto	nsy finding	s available
Re	The lav	ш									auto		2.10.	prior to co death?	mpletion of	cause of
a	n: T sficete or, pa		25. Was case referred to medical						00 01	(D)	- ~	2 N	0	1 Yes	2□ No	
5	ysicien: is certific director,	o Be	examiner? 1 X Yes 2 No	Hospital:	Inpatient	2 ER/Outpatie	nt 3 🗆 DO	Othe			h <i>(Check only</i> me 5□Res		c X X	has (Canaii	at s	scene
o	ding Phy h. After this funeral d	7: To	27. Manner of Death	28a, Date	of Injury	28b. Time		8c. Injury Work		raing no	28d. Describe				y) a o ,	300110
o	th: After: After	tion	1 □Natural 5 □ Pendin 2 X Accident investig	9	th, Day 1			Work 1 □ Y	? ′es 2.⊠4l	No	apar	me	nt 7	Fire		
N N	Atter r dea ector by th	ifica	3 ☐ Suicide 6 ☐ Could in determine	ined 286. Plac	e of Injury	/ - At home, farm, si		, office			28f. Location					
	el or s afte N Dir	Certification:	4 [] Holflicide	bullo	ing, etc.	LOWITY	+				City or To	15+ W	18-5+-	Hwyi	Silver	Sprys,
	ospit hour uners ly fille			g Physician: To th	e best of	my knowledge, dea	th occurred a									(-)
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2X Medical one)	Examiner: On the t	nar state	xamination and/or i	ivestigation,	in my op	iriion, dea	un occuri	ed at the time	, date ar	id place,	and due to	o ine cause	(5)
	To t	Σ	29b. Signature and title of certifier					. License	number				_		Day, Year)	
			Jans Las	Green	P	Nep	0	CME				Ap	ril	15, 2	2005	
	3		30. Name and address of person	4		th (Item 23a) (Type	Print) 1	11 12	onn (Z+ rec	o+ Do1	+	2100	M	1 1	21201
			Tasha Z Gr	eenper	75	M.R.		TT P	eilli S	orre	et Bal	LIMO	ore,	Mary		ZIZUL
	Sta		31. Date filed (Month, Day, Year)	OCCE	degistrar	s Signature	us!									
	Registr	ar	APR 19	LUUD BE	A STORES	- //										

John Seidel 05-2612 AKG

512			For Stete Registrer	State of Ma	aryland / Depa	artment of F		_	giene 005	13225
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medic		John G.	Seidel				April	14, 2005	5:50 A M
	Examin	er	4a. Facility Name (If not institution,		110		r Location of Death		4c. County of Dea	
			1220 East West 1		L L() pe (In yrs. last birthday)	Silver S		8. Date of Bir	Montgo	omery httplace (State or Foreign
н	Funeral Director		297*24*5897	1 ☐ M 2 ☐ F	75 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Aug. 19.		veland, OH
	P .		Usual Residence of Decedent					11001221		
	arylar ahow	_	10a. State 10b. County MD Montge	omerv	10c. City, Town or Lo					10d. Inside City Limits 11 Yes 2 No
	he M	ectc	10e. Street and Number	Alex y	DIIVCI D	10f. Zip Code			10g. Citizen of What C	
	a or	ä	1220 East West High	h ny Ant # 111/	٦		0910		United State	
	filed within 72 hours after death with the Maryland Hygiene. that than "natural", or Items 23a or 28a-f ahow int, the Madical Evaning must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?			dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		erican Indian,
9	after or item	Ē	1 Never Married 25 Marrie	ed 1 📆 Yes 2 🔲 .	No 1051- I		an, Mexican, Puerto Specify:	Rican, etc.)		ite, etc.
5-0036	ours Fral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1954	1 ☐ Yes 2 ☐ No				Black
15-(nati	Completed	15. Decedent' (Specify only highes		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business	s/Industry
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9	illed Hygi othar	Be C	17. Father's Name (First, Middle, L			resitat	18. Mother's Nam	e (First, Middle	, Maiden Sumame)	
/lan	uld be Menta Irkad tic av	To B	John Rickman Seide	e 1			Olga Maxi	ne Smith		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygie		19a. Informant's Name/Relationsh			-			er, City or Town, State,	Zip Code)
Σ,	and sealth m 27		Vanessa King/ God	laughter			t N.E. Was			T Chat
Baltimore,	ges 1 t of H Hital		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 ☐Removal from State	I	matory or other pla	ce)	Date /2005	20c. Location - City o	
tim	it. Pa rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Fundral Service L		Ft. Lincoli		1	/2005	Brentwood, M	ע
Ba	Depar Depar Impor		supero h	mpse		401 Bladens			Funeral Home d, MD 20722	
			23a, Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	d the death. Do not entine.	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Smoke a	nd Supt in h	alatan c	amplication	ic after	rocclenotic	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	Car	dibasci	leur du	sease	
		-	Sequentially list conditions,	b. — Due to (or as	a consequence of):					
T	uted i insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
v	be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequence of):		<u></u>			
8760,	cate be executed bhysician and the burial-transit	cal		d						
89	rtifica ng ph as th	by Physician/Medical	IF FEMALE:	1						
Вох	The law requires that the death certifics the has been signed by the attending phage 2 should be detached for use as the	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	у		23d. Date of de Month	elivery Day Year
0.	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown	t time of death 5	Other (specify) _				,
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Records,	uires r sign ld be	d b						120	Yes 2 □No 3 □ F	robably 4 Unknown
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Re	The lav cate has page 2	omp						auto perfo	ormed? death?	s 2 No
	10	BeC	25. Was case referred to medical				26. Place of Deal		-	2 2 10
_f <	Physician: r this certific ral director,	To E	examiner? M☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatio	ent 2 ER/Outpatier	nt 3 DOA Oth	ner: 4 🗆 Nursing Ho	ome 5 ☐ Resi	dence 6XXX ther (Sp.	ecify) at scene
n of	ding Ph h. After thi funeral	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da		Wai	rk?		how injury occurred	
sio	Attanding r death. actor: After y the fune	cati	2 Accident investig 3 ☐ Suicide 6 ☐ Could n	ation from 14 2	005 5:19	/	Yes 2010		authent t	
Division	or At after o Diracl in by	Certification:	4 Homicide determi	ned 28e. Place of In building, ef	jury - At home, farm, st tc. (Specify)	4		City or To	Street and Number or F wn, State)	Hwy Silver
	spital ours a naral l		29a. Certifier 1 ☐ Certifyin	g Physicien: To the best	of my knowledge, deat		me, date and place.			Spyling, PLD
	To tha Hospital or within 24 hours afte To tha Funaral Dirrocompletely filled in In	Medical		Exeminer: On the basis of and manner st	of examination and/or in					
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	1	4	29c. Licens			29d. Date signed (Mor	nth, Day, Year)
			Sarke	Voree	1 no	OCME	C		April 14	. 2005
	/		30. Name and address of person		death (Item 23a) (Type,		Dom:- Ch	ah D.7	_	
	5			eenberg	M.U.		Penn Stre	et Bal	limore, Ma	ryland 21201
*	Sta Registi	7.00	APR 1 9 2	005 Figure 2	rar's Signature	de la				

Theodore C. Street Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 24711- State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a,27,28a-f per me 1343 5-5=05 tras AJG 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 8, 2005 5:45 Рм Theodore C. Street Jr /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Wheaton 14225 Grandpre Road #301 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**™** M 2□ F Yrs Director 117K May 17, 1967 Pennsvlvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 28a-f show traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director DCWashington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a 518 8th Street NE 20002 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status e filed within 72 hours after de I Hygiene. other then "neturel", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w. h and Mental Hygien 7 Is marked other th Vice President Delivery Service 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marva R. Robins Theodore C. Street Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health at Important: If item 27 Is eny injury or other trau once. Marva R. Street - Mother 518 8th Street NE Washington DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 4/15/05 Ft. Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Service Nicensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Alcohol Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 1 Tes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death. 1 Yes 2 No 1 Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Nursing Home 5 Residence 6 Other (Specify) at scene 2 1XYes 2 No this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury Fournament, Day Year) After Certification: Found 5:30 5 Pending investigation 1 Natural 1 ☐ Yes 2 XNo 2 Accident 4-8-05 3 Suicide

Hospital or Attending Physicien: after death. within 24 hours a

6 X Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 14225 Grandpre Rd. Wheaton, Md

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number

29b. Signature and title of certifie

O.C.M.E.

29d. Date signed (Month, Day, Year) April 9, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 1 9 2005

4 | Homicide

gistrar's Signature

KURELL

111 Penn Street, Baltimore, Maryland 21201

the

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Medical

State

			For State Registrar	State	of Maryland		artment of F	lealth and M Death		giene No. 05	13227
	Physici /Medio Examir	al	Decedent's Name (First, Midden Winifred Wan Facility Name (If not institution)	V.		2	4b. City, Town, o	r Location of Death	2. Date of Dea Month	Pay Yes	5 12:3/AM
	Funeral Director		Franklin San 5. Social Security Number 086-12-7912	6. Sex 1 M 2 N F	7. Age (In yrs. In 87	*	R 6 S C If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 6,	B \(\sqrt{9.1} \) 1917 N	Figure 1 Country) Jew Jersey
	vith the Maryland or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. Count Maryland Balt 10e. Street and Number	imore	10c. City	, Town or Lo Par	cation kville			log, Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Country?
99	ier death v Items 23a	by Funeral Di	8820 Walther 11. Marital Status 1 Never Married 2 Ma 3 WWidowed 4 Divorce	12. Was De	ecedent Ever in U.S Forces? s 2 X No Give	S. 13. \	2123	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Specify:	merican Indian, hite, etc. White
Fred 121215-0036	be filed within 72 hours ital Hygiene. id other than "natural", evant, Ite Medical Ex-	Completed	15. Decede (Specify only high) Elementary/Secondary (0-12) 12	nt's Education est grade complete College		(Give life. I	lent's Usual Occup kind of work done OO NOT use retired nemaker	during most of work d)		16b. Kind of Busine	ss/Industry
Warvland Marvland	2 should and Mer Is marke	To Be	17. Father's Name (First, Middle Nicholas 19a. Informant's Name/Relation	ship (Type, Print)	/anderval	19b. Mailin	,		al Route Numbe	Dykstra r, City or Town, State	
Singe(permit. Pages 1 and 3 Department of Health Important: if itam 27 any injury or other tru once.		Daniel D. Sin 20a. Method of Disposition 1 Burial 2 Micromation 4 Denation 5 Other (3 □Removal fro	m State 20b. Pt	ace of Dispo metery, cren ional	sition (Name of natory or other place Cremator	y 4/21	/05		or Town, State rch, Virginia
	Puysician /Medical Examiner		Bryan W. C.1 23a. Part1. Enter the disease, cancer, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due	to (or as a consequ	Do not ento	W. Pado	nia Road,	Timoni		Approximate Interval Between Onset and Death
68760.	tificate be executed ig physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying cause: (Decase of high that initiated events resulting in death) Last	\$	to (or as a consequito (or as a consequi						
P.O. Box 6	at the death certif by the attending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live	outcome of pregnar e birth 2 Fetal egnant at time of de known	death 3	Ectopic pregnancy Other (specify)	y		23d. Date of Month	delivery Day Year
cords. P	w requires that been signed t should be det	ompleted by P	Part II. Other significant condit Hyfertesic Reast co	_		lting in the ur	nderlying cause giv	en in Part I.	1	es 2 No 3	e to the cause of death? Probably 4 Unknown autopsy findings available
Vital Re	sician: The lav certificate has irector, page 2	o Be Comp	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	al		ER/Outpatien	t 3 DOA Cth	26. Place of Death	h (Check only or	med? death 2 No 1 Y	to completion of cause of ?? es 2 No
Division of Vital Records.	or Attanding Physician: The law requires that the death certificatafer death. Director: After this certificate has been signed by the attending print by the funeral director, page 2 should be detached for use as the	Certification: To	27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could	28a. Da (Mi tigation d not be		28b. Time of Injury	28c. Injur Wor M 1	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical Ce	(Check only	I Examiner: On the and m			estigation, in my o	pinion, death occur	ed at the time, d	ause(s) and manner ate and place, and c	lue to the cause(s)
	T with	<	29b. Signature and title of certification. 30. Name and address of person	EP-Hi	ause of death (Item	23a) (Type,	29c. Licens	61251		9d. Date signed (Mc	25
	Sta Registi		31. Date filed (Month, Day, Yea.	E -H †	Registrar's Signat	ure	NKIIA	Squal	e Drivi	Baltim	ore, mD 21237

			For State Registrar	State of Man		artment of H		d Mental Hy	giene	5	13228
			Decedent's Name (First, Middle, L	ast)				2. Date of De	eath	Vass	3. Time of Death
	Physici /Medio		Natalie	Elise	Sheppa	ard		April	14, 2	Year 005	2:15 P ^M
	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of D	eath	4c. County	of Death	
			Stella Maris			Timoni				1time	ore
	Funeral		Social Security Number 6.	1 TM 200 F	In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	rth ay, Year)	Coui	
	Director		212-10-0463 Usual Residence of Decedent	9	3 Yrs.			June 6	, 1911	New	York
	land wo		10a. State 10b. County	1	0c. City, Town or L	ocation				1	Od. Inside City Limits
	Mary fed	ō	Maryland Baltim	ore	Timoni	ım					1 ☐ Yes 2 💢 No
	the north	Director	10e. Street and Number	ore	TIMOIII	10f. Zip Code			10g. Citizen of	What Coul	ntry?
	38 or		2300 Dulaney Val	ley Pond		210	93		USA		
	ms 2	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.			? (Specify Yes or No ruerto Rican, etc.)			can Indian,
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-1 show other traumatic event, the Marical Examiner must be notified at	Ē	1 Never Married 2 Married			1 ☐ Yes 2 ☑ No		derio rican, etc.)		ck, White,	etc.
21215-0036	rai,	1 by	3	If Yes, Give Year or Dates:		10 185 ZKINO	эреспу.		Specif	Wh	ite
5-0	72 h	Completed	15. Decedent's (Specify only highest of	Education trade completed)	(Give	dent's Usual Occup	during most of	working	16b. Kind of B	usiness/In	dustry
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and	be fi	Be						•			
3	2 should be f and Mental I is marked of sumatic eve	ဥ	August 19a. Informant's Name/Relationship	Knofler	40h Mail	- Address (Cares	Maı	r 1e or Rural Route Numb	Rice		Codel
Maryland	d 2 si th an 7 is r traur	8 3	·								
	Health tem 27 other tra		Stephanie S. Cut 20a. Method of Disposition		20b, Place of Disp	osition (Name of		rive, Lill	20c. Location		
Baltimore,	permit. Pages 1 a Department of Hes mportant: If item any injury or othe		1 XBurial 2 ☐ Cremation 3	Removal from State		matory or other place	1	00/05			
語	mit. Pa partmen cortant: injury		'4 □ Donation 5 □ Other (Special Service Light)		Loudon Pa	rk Cemete 2. Name and Addres	The second secon	20/05	Baltime	ore,	Maryland
Ba	permit. Pages 1 Department of H important: If ite any injury or ot once.		Dilla	leexit	•	Lemmon Fur	neral H	Home of Du	laney V	alle	Inc.
			23a. Part1. Enter the disease, or co	molications that caused th	ne death. Do not en	ter the mode of dvin	onia Ro	oad, Timor	nium, Ma arrest	rylai	Approximate
			shock, or mart fullure. List on Immediate Ca. se (F) al	ly one cause on each line.							Interval Between Onset and Death
	Physician /Medical		disease or con Hi resulting in death)	a 5 FU	IZNR D	ZMANTA	5 x	LZIFE	MEA'S		2 Y FIRS
	Examiner			Due to (or as a d	consequence of:	2000		0.5	1411	2	Z
		<u>_</u>	Sequentially list conditions,	b. Due to (or as a o	consequence of):		_			-	
A	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Ø	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a c	consequence of):						
8760,	siciar buri			d							
89	ificate g phys as the	Physician/Medical		- U.							
Вох	leath certifica attending ph I for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75.4			23d. Da	ite of deliv	ery
œ.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin		□Ectopic pregnancy □ Other (specify)			Mo	onth	Day Year
P.O.	that the de ed by the detached	hys	9 ☐ Unknown	9□ Unknown							
ď.	res tha igned be del	by P	Part II. Other significant conditions	contributing to death but	not resulting in the i	inderlying cause giv	en in Part I.	23e. Did	tobacco use con	tribute to t	he cause of death?
Ď	v require been sig should b		- PULT	TIMARY F	(BINGSIS			_ 10	Yes 2	3 Prol	pably 4 Unknown
000	s bee	Completed						24a. Was	s an 24b.	Were auto	ppsy findings available impletion of cause of
R	The lay te has age 2 :	E O						— auto perf 1 ☐ Yes	ormed?	death?	
Division of Vital Records,	an: Tifica Tor. p	40	25. Was case referred to medical				26. Place of	Death (Check only		100	
Ξ	ysici is cer direct	To B	examiner? 1 ☐ Yes 2 ሺ No	Hospital:	2 ER/Outpatie	nt 3 DOA Oth		ng Home 5 ☐ Res		ner (Specia	(y)
0	g Ph er thi		27. Manner of Death	28a. Date of Injury (Month, Day Y			y at		how injury occur		
0	ath: r: Aft e fun	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		roar/ injury		Yes 2 □ No	6			
<u>Vis</u>	Atte	if Ca	3 ☐ Suicide 6 ☐ Could not determine		y - At home, farm, si	reet, factory, office		28f. Location	(Street and Numl	ber or Rur	al Route Number,
	s afte	Certification;	TO HOUSE	ballang, etc.	(Opochy)			0.19	, 0.2.07		
	ospit hour unera ly fills		29a. Certifier 1X Certifying (Check only 2 Madical Ex	Physician: To the best of aminer: On the basis of e	my knowledge, dea	th occurred at the tir	ne, date and p	place, and due to the	cause(s) and m	anner as s	tated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and complistely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledicai	one)	and manner state				ooddinga ar are arrie			
	To the Com	Σ	29b. Signature and title of certifier	- 1		29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
	.4		Walte N	mely M	7	1000	1/20	39	April	18,	2005
	1,	1	30. Name and address of person wh	o completed cause of dea	ith (Item 23a) (Type	, Print)					
			Walter R. Welzar	nt, MD PA, 76	600 Osler	Drive, T	owson,	Maryland	21204		
		ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature						
	Regist	rar	APR 1 9 20	05 Kg	H does	R.S					
DH	MH 17 Rev 1/2	2001	0 20	Blown.	1						
					ORIGIN	AL					

			For State	State of Maryland / [Department of Hea				13229
			Registrar 1. Decedent's Name (First, Middle, Last		Octimeate of Be		Reg. I	No.	3. Time of Death
	Physici	an	10:11.	(; 777				Day Year	
	/Medic		V 0	tert III	4h City Town and a	pasting of Dooth	4	4c. County of Death	- 1728 M
4	Examir	ier	4a. Facility Name (If not institution, give	1 1 .1 .1 .1	4b. City, Town, or Lo	2			and al
			5, Social Security Number 6. Se	del Hospital	thday) If Under 1 Year If	f Under 24 Hrs. 8	Date of Birth	Anne Av	ace (State or Foreign
	Funeral Director		212-44-2112	V.,		Hours Min.	(Month, Day, Yea	ar) Coun	(ry)
			Usual Residence of Decedent			ĮM.	ay 11, 19	945	MD
	land ow		10a. State 10b. County	10c. City, Tow	n or Location			10	d. Inside City Limits
	Man-f sh	ţo	MD Anne	Arundel	G1en	Burnie			1 ☐ Yes 2 No
	the	rec	10e. Street and Number		10f, Zip Code	2011110	10g. (Citizen of What Coun	try?
	3 with	O I	115 Second Aven	10 SE	21	1061		US	٨
	death ms 2	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban,		Yes or No-	14. Race - Americ	an Indian,
ယ္	or Ite	Ē	1 ☐ Never Married 2X Married	Armed Forces?	-]		an, etc.)	Black, White,	otc.
03	al', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1968	1 ☐ Yes 2 🕅 No 3	Specify:		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a.	Decedent's Usual Occupation	on	16b.	Kind of Business/Inc	ustry
21	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done duri life. DO NOT use retired)				
21	gien gien er th	Con		2	Lieutenant /	/ Fireman		Fire Prot	ection
bu	al Hy l oth	Be (17. Father's Name (First, Middle, Last)		18	B. Mother's Name (F	irst, Middle, Maid	len Sumame)	
/lai	uld b Ments rrkec	To	William Seifert,	Jr.		Peggy C	'Neil		
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 le marked other than " treumatic event, the Med		19a. Informant's Name/Relationship (T)	rpe, Print) 19b	. Mailing Address (Street and	d Number or Rural R	oute Number, Cit	y or Town, State, Zip	Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event. The Medical Examinat must be notified at		Mrs. Kathleen Se		115 Second Av	renue, SE,	Glen	Burnie, M	D 21061
re	of He item		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ F	A a made	f Disposition (Name of ry, crematory or other place)	Date		Location - City or To	wn, State
Ĕ	Pages nent of I int: If it		'4 □Donation 5 □ Other (Specify)	Meadow	vridge Mem. Pa	ark 4/18/	2005	Elkridge	, MD
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra 20ce.		21. Signature of Funeral Service Licens	96	22. Name and Address of			Funeral	
m	Deparential Depare		Mark le Va	neural Mo135	7 1 Seco			Burnie, M	
	a.		23a. Part1. E disease, or comp	ications that caused the death. Do					Approximate Interval Between
	Physician		Immediate Cause (Final	M. I.					Onset and Death
7	/Medical	Ш	disease or condition resulting in death)	a Due to (or as a consequence	of):				d hrs.
	Examiner			CAD	,				
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):				
	uted d ansit	Examiner	Cause (Disease of injury that initiated events	TYPET D	19111105				
Ć,	өхөс In an ial-tr	Exa	resulting in death) Last	Due to (or as a consequence	of):				
8760,	icate be executed physician and s the burial-transit	dicai		d					
9		ledi							
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	2 Catagia areas and			23d. Date of delive	у
	that the death red by the atter detached for u	icia	in the past 12 months? 1 2 Yes 2 No	4 Pregnant at time of death	3 ∐Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P.0	by the	hys	9 ☐ Unknown	9□ Unknown					
	es tha igned be det	by P	Part II. Other significant conditions co	ntributing to death but not resulting i	n the underlying cause given i	in Part I.	23e. Did tobacc	o use contribute to th	a cause of death?
rds	quire in sig uld b	De L	PAD				1 🗌 Yes	2 No 3 Proba	ably 4 Munknown
Records,	w requires been si	iete	Hyperlin	pidemia			24a. Was an	24b. Were autop	sy findings available
Re	sicien: The law requires that the death certific certificate has been signed by the attending I irector, page 2 should be detached for use as	Completed	LITA!	7,00,7,70			autopsy performed	? death?	npletion of cause of
Vital			25. Was case referred to medical		2	6. Place of Death /C	1 Yes 2	No 1 ☐ Yes	2 NO
>	Physicien: this certificatal director, it	o Be	examiner?	Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Other:			6 ☐Other (Specify	3
of	Phys or this eral di	\vdash	27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at		Describe how in		
on	iding F th. After funer	tiol	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		s 2 🗆 No			
Division	Attending or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, fa	arm, street, factory, office	28f.	Location (Street	and Number or Rura	Route Number,
Di	after Dire	Certification:	4 Homicide	building, etc. (Specify)			City or Town, Sta	ate)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	aic	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge	e, death occurred at the time,	date and place, and	due to the cause	(s) and manner as st	ated.
	1 24 h	Medicai	(Check only 2 Medical Examone)	ner: On the basis of examination an and manner stated.	nd/or investigation, in my opini	ion, death occurred	at the time, date a	and place, and due to	the cause(s)
	To th Withir To th Somp	Me	29b. Signature and title of certifier	1 11	29c. License n			Date signed (Month, L	
			////	0100	H00	52510	1	4-18-05	
	10		30. Name and address of person with c	ompleted cause of death (Item 23a)	(Type, Print) 0. 202 W.				
	1		Dr. Allen Crai	a Fisher D.	0. 202 10.	Maple 1	ed. Lin	thicum r	109n
24	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		T			
*	Regist	rar	APR 1 9 2005	person it is	DE ASE				

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State of Maryland	/ Department of Health and	d Mental Hygiene 🛭 🗍

of Frint in Black macriple link. Lindare	til oopies Ale Legible.	
ate of Maryland / Department of Health and	Mental Hygiene 🛭 🗎 5	13230
Certificate of Death	Reg. No.	

2. Date of Death

3. Time of Death

	1. Decedent's Name (First, Middle, Last)
Physician /Medical	Huseyin
Examiner	4a. Facility Name (If not institution, give s

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heathh and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

sician ledical	Huseyin Sariaydin	Apri	1 17, 2005 2345 P M
miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Laurel Regional Hospital	Laurel	Prince George's
eral tor	5. Social Security Number 1.6. Sex 1. M. 2. F. Age (In yrs. last birthday). Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Jan.	f Birth a, Day, Year) 1,1957 9. Birthplace (State or Foreign Country) Turkey
4	10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
Ď	New Jersey Burlington Burling	ngton	1 □ Yes 2 🛣 No
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
i o	657 Park Avenue	08019	Turkey
Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc.
<u> </u>	1 ☐ Xever Married 2 ☐ Married 1 ☐ Yes 2 1 No	1 ☐ Yes 2X No Specify:	Specify: Turkish
od by	3 Widowed 4 Divorced Year or Dates:	death level Occupation	
Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation The kind of work done during most of working TOO NOT use retired)	16b. Kind of Business/Industry
Juo	Elementary/Secondary (0-12) College (1-4or 5+)	ainter	Painting
e o	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	
0 B	Mutu Sariaydin	Hurmuz Unkn	own
		ing Address (Street and Number or Rural Route N	
eny injury or other treumelic event, it is modelle Extensive countries at once. To Be Completed by Funeral Director		Park Avenue, Burlington	
	1 YBurial 2 Cremation 3 Hemoval from State '	matory or other place)	20c. Location - City or Town, State
n l	`4 ☐Donation 5 ☐Other (Specify) Kesap Ce		
DCe	the state of the s	2. Name and Address of Facility ISIamic 251 De Kalb Ave., Brook	Funeral Services, Inc.
9 CI	July 100		
	23a. Part1. Enter the Lease, ir complications that caused the death. Do not en shock, or heart fillure. List only one cause on each line.		Interval Between Onset and Death
ian	resulting in death)	diovascular disease	
cal ner	Due to (or as a consequence of):		
e e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
z snould be detached for use as the burfar-transit pleted by Physician/Medical Examin	resulting in death) Last Due to (or as a consequence of):		
cal	d		
Wed ba	IF FEMALE:		
vsician/Medical	23b. Was decadent prograpt 23c. If yes, outcome or pregnancy	□Ectopic pregnancy	23d. Date of delivery Month Day Year
Sici	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 5	Other (specify)	
Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. 1	Did tobacco use contribute to the cause of death?
A P		, , , , , , , , , , , , , , , , , , , ,	1 Yes 2 No 3 AProbably 4 Unknown
etec		240.1	Was an 24b. Were autopsy findings available
Completed			berformed?
3	25 Was case referred to medical	1/ Z (Y	es 2 No 1 XYes 2 No
o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No Hospital: 1 □ Inpatient ★ X XER/Outpatie	26. Place of Death (Check of them and the state of Death (Check of the state of the	nly one) Residence 6 □Other (Specify)
7: T	27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at 28d. Descri	ribe how injury occurred
i i	1 1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
ii iii	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Homicide 6 ☐ Could not be determined 5 ☐ Homicide 6 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 7 ☐ Homicide 7 ☐ Homi		on (Street and Number or Rural Route Number, r Town, State)
Certification:	a multing, etc. (Specify)	Only of	Tomi, state)
completely filted in by the function page Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
dung W	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
г	I Janhar Treentee No	OCME	April 18, 2005
X	30. Name and address of person who completed cause of death (them 23a) (Type		altimore Marriand 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signiture		altimore, Maryland 21201
State gistrar	APR 1 9 2005 Man	1. Speles	
v 1/2001	11 11 x 0 2000 1000		

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Evelyn I. Sibley April 16, 2005 2:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Long View Nursing Home Manchester If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours 1 ☐ M 2 🗗 F 86 216-12-2684 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Ia marked othar than "natural", or Items 23s or 28a-f show traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Carroll Manchester Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 19405 Gunpowder, Rd. 21102 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Ia marked othar than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Parent Md. School for Blind 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lawrence Joshua Meekins Ella Harmon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19405 Gunpowder Rd., Manchester, Md. 21102 Debbie Benson - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. Evergreen Mem. Gardens Apr. 20,2005 Finksburg, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ronasc disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed anding physiclan and use as the burial-transit with Se that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No 24a. Was an has e 2 certificate ha rmed? 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 70 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No Diractor: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month, Day, Year) Registrar s Signature State APR 1 9 2005 Registrar

State Registre AMEND ITEM #1 PER PHY G842 4920/109 tompf Death Reg. No. 2. Date of Death, 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** TENSING Mary Stiebing FIPRIL 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NORTH WEST HOSPITAL RANDIALLS TOWN
If Under 1 Year | If Under 24 Hrs. | 8. Date
Months | Days | Hours | Min. | (Mon BALTIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛛 F 88 216-36-8137 Director Sep. Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r then "naturel", or Items 23e or 28e-f show the Medical Exam, inclinished at MD Y☐Yes 2☐No N/A Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6811 Campfield Road 21207 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Parlor Hairdresser permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other treumatic event 2016. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Patrick H. Thompson, Sr. Frieda Kerbe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert H. Stiebing, Jr. Son 208 West Elpin Drive, Catonsville, MD 21228 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Lorraine Park Surial 2 Cremation 3 Removal from State ' 4 □ Donation 5 □ Other (Specify) 4-16-2005 Baltimore, MD Cemetery 21. Signature of Fune at Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 11328 Sulphur Spring Rd., Arbutus, MD 21227 2.1a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MEUMONIA /Medical Due to (or as a consequence of): **Examiner** HEART FAILURE DHUGESTIVE Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) 4 Pregnant at time of death by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate 2 No 1 Tyes 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerel C
completely filled i the Hospitel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 13

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $J_{561106}RPMEHTA$

CENTER

32. Registrar's Signature

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HOSPITAL

MIRTHWEST

31. Date filed (Month Day Year) 9 2005

outherland, Robert

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrer Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Robert B. Sutherland Apri 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town or Location of Death Examiner Darchester Cambridge
If Under 1 Year If Under 24 Hrs. General Hospita Dorchester 8. Date of Birth (Month, Day, Y April 9, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** . 1927 Months Days Hours Min 10XM 20 F 220 22 4087 78 Director Mary land Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dorchester Hurlock Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21643 4456 Blink Horn Road Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (፮Ves 2 □ No If Yes, Give Year or Dates: ₩₩ II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XMarried ŏ 1 ☐ Yes 2 A No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) School Board and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Delivery Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Sutherland Marjorie Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4456 Blink Horn Road Hurlock, Maryland 21643 item 27 Edna Sutherland / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 jo 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Dept riment of Important: if any injury or once. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 4/18/2005 21. Signature of Funeral Service Licen 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 romerous e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Pulmonary Immediate Cause (Final Priysician Hemorrhage I hour disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Respirator Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) by Physician/Medical Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician for use as IF FEMALE 23c. If yes, outcome of pregnancy
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1 2 7 es 2 □ No 24a. Was an funeral director, page 2 autopsy performed 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ₽ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Anatural death. 1 🗌 Yes 2 No s after death. 2 Accident filled in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04-13-05 U0053253

Registrar
DHMH 17 Rev 1/2001

State

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32. Registrar's Signature

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Lednum

AVE

Preston, MO 21655

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SNIEZEK

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APR 1 9 2005

31. Date filed (Month, Day, Year)

Sommerwerch, Elizabeth

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yland		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) April 15, 2005 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Din Alia Occo 560 Legan Range Black Balkingre MD2/239		24 h	dlog	(Check only 2 Medical Exami	ner: On the basis of exan	nination and/or	investigation, in my	opinion, death occu	red at the time,	date and place,	and due to	the cause(s)
Ondriver, mp Doos 9855 April 15, 2005 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Oin alia Gas 560 Lean Runn Blue Bulkingre mD 2/239		o the o the omple	N N	29b. Signature and title of certified			29c. Lice	nse number	T	29d. Date signe	d (Month, E	Dey, Year)
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Dinalia Gao 560/ Loch Runn Blud Baltimore MD2/239			5	30. Name and address of person who co	ompleted cause of death	Item 23e) /Tvr	pe, Print)	- 10-	/	1	-	
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	COUNT.	- JAVV - J	-	1000		

Registrar DHMH 16 Rev 6/95

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 1 per phys 8842 4-28-05 vt
State of Maryland Poepartment of Health and Mental Hygiene 15

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Cordel1 P. Thomas Sr. 10:12 AM April Cordell P. Thomas 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Lanham Doctors Community Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 XM 2 F Yrs. 227-48-8396 Director 66 Washington DC Oct 16, 1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other treumetic event, the Medical Examiner nust be notified at 1 Yes 2 No Director MD Hvattsville Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20785 U.S.A. 7609 Burnside Road Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married ŏ 1 ☐ Yes 2 🛣 No Saltimore, Maryland 21215-0036 Specify: Specify: Black. 3 ☐ Widowed 4 ☐ Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Press Operator Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental and Mental Catherine Thomas Unobtainable ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7609 Burnside Road Hyattsville MD 20785 f Health item 27 I Arnetta B. Thomas-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ö Department of Importent: If any injury or once. 4/19/2005 Brentwood, MD Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequend **Examiner** Or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury taw requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician a for use as the burial Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant. 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. | signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Minknown Completed cate has been s 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2√ No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2% No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: At death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M DID 16410 APRIL 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1508 HANDELL PARKWAY SUITE 105 COREENBELT MA GABRIEL B. JAFFE M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra APR 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer 2:10 PM OU Omaken 2003 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore** Future Care Canton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days 1,50M 2□ F **Philippines** Yrs. 02-05-1921 84 220-90-8127 Usual Residence of Deceden 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 No Randallstown **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 U.S.A. 3733 McDonogh Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify Asian 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banking Check Processor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Potenciana Ybanez Rosaleo Tomakin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3733 McDonogh Road Randallstown, Maryland Mrs. Thelma Elum 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2.5 cremation 3 ☐ Removal from State 04-20-2005 Falls Church, Virginia National Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signature of Juneral Service Licensee 8728 Liberty Road Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rteriosderate Comay VALOGOD (paads ue to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Ostrochem Volorman 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

certificate be executed

Box 68760.

P.O. I

Vital Records,

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Division

or Attending Physician:

To the Hospital

Physician

/Medical

Examiner

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Moulcal Examinar must be notified at

within 72 hours after death with the Maryland

is 1 and 2 should be filed with of Health and Mental Hygiene. Item 27 Is marked other than

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau once.

Maryland 21215-0036

Baltimore,

Examiner the burial-transit and physician Physician/Medical esn the signed to as been si Completed has rector, page After this Certification: within 24 hours after death.

To the Funeral Director: A completely tilled in by the to

that initiated events resulting in death) Last	c. Due to (or as a consequence of	f):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day	Year
Part II. Other significant condition	ons contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the caus	e of death

le orenja 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 NO

25. Was case referred to medical examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2.☐ No 28b. Time of

Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 Tes

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 -Natural 5 Pending investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide

sairo do

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only 29b. Signature and title of certifier

4 Homicide

Olichoel

Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Ditches Hichery \$ 508 Glen Brices, Maryland 21061

(levavie) Melecel person who completed cause of death (Item 23a) (Type, Print) 30 Name and address

determined

D19667

04-16-2005

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 9 2005

7310 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiefie For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** 10:55 PM Olfat Tera **April** 12, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Ars. | 8. D Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. Director February 10, 1932 105-38-5851 Egypt Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturet", or items 23e or 28e-f show any injury or other treumatic event, in Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Bluff Terrace 20902 United States Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕅 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemist Research 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Salem Abrahim Farag Rose Notenagel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Bluff Terrace Silver Spring, Maryland 20902 Fouad Tera/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State April 19, 2005 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Fune al Service Licensee let Danie Bethesda, Maryland 20814-3501 MU13U5 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Toxic Metabolic Encephalopathy /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Acute Renal Failure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Pneumonia Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) detached 9. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Metastatic Leiomyosarcoma 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Disseminated Intravascular Coagulation 24a. Was an autopsy performed 1 ☐ Yes 2 X No nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Certification: To 1 ☐ Yes 2X No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier cal 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 47867 April 13, 2005 who completed cause of death (Item 23a) (Type, Print) 30. Name and a ess of p Oney Zaniga, M.D Randolph Road #101 Rockville, Maryland 20852 4701 31. Date filed (Month, Day, Year) State APR 1 9 2005 Registrar

	State of Sta	f Maryland / Departn <i>Certifi</i>	nent of Health and N cate of Death	Mental Hygien Reg. N	7000 10502
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dical	4a. Facility Name (If not institution, give street and nur.		City, Town, or Location of Death		c. County of Death
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	N/B 495 south of Central 5. Social Security Number 6. Sex		rgo Jnder 1 Year If Under 24 Hrs.		Prince George's
al or	156-50-2254 Security Number 6.5ex 1\\$\text{X} M 2□F		nths Days Hours Min.	(Month, Day, Yea	
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	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locatio	n		10d. Inside City Limits
7			D		1 ☐ Yes 2 🛣 No
Director	DC N/A		District of		
ä	10e. Street and Number	10	of. Zip Code	10g. C	Citizen of What Country?
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Funeral	11. Marital Status 12. Was Dece Armed Fo	edent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (S., specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
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2	Keith L. McGregor 19a. Informant's Name/Relationship (Type, Print) Mo	19h Mailing Ac	dress (Street and Number or Ru		
	Rosamaria Valderrama-McG			ılm Bay, FL	
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from	20b. Place of Disposition cemetery, cremator	y or other place)	Date 20c.	Location - City or Town, State
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	21. Signature of Eunera Service Licensee	22. Na	ne and Address of Facility Mation Society	- F MD T	
	restard of we	Cre	mation Society	oi MD, Ind	C. MD 21220
	Edward A. Gregorchik 23a. Part1. Enter the disease, or complications that of		Frederick Road		Approximate
	shock, or heart failure. List only one cause on e	each line.	,	,,	Interval Between Onset and Death
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by F	Part II. Other significant conditions contributing to d	eath but not resulting in the under	ying cause given in Part I.		o use contribute to the cause of death?
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	27. Manner of Death 28a. Date	of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
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C	3 Suicide 6 Could not be determined 28e. Place	e of Injury - At home, farm, street,		28f. Location (Street	and Number or Rural Route Number.
-	4 Homicide determined build	ing, etc. (Specify)	•	City or Town, Sta	ate) N/B 495 south of ce
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Certification:	20- 0-49-	a bast of my knowledge, death occ	at the time, date and place gation, in my opinion, death occu	e, and due to the cause urred at the time, date a	nd place, and due to the cause(s)
	29a. Certifier 1 Certifying Physician: To the (Check only 2 Medicel Examiner: On the base)	pasis of examination and/or investi			
edical	(Check only 2 Medical Examiner: On the b	pasis of examination and/or investi	100 11		3-1
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edical	29b. Signature and title of certifier When the bound of	iner stated	OCME	Apr	ril 12, 2005
Medical	29b. Signature and title of certifier When the boundary of th	iner stated	OCME	Apr	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29 **Physician** /Medical 4c. County of Death City, Town or Ljocation of Death 4a. Fecility Name (If not institution, give street and number) Examiner N/Aつひょ Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Novembrian Day, Year 27 9. Birthplace (State or Foreign Maryland **Funeral** 77 213-20-5092 1 X M 2 □ F Yrs. Director Usual Residence of Decedent filad within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show 7 is markad othar then "neturel", or items 23e or 28a-f shov treumetic event. The Modical Examinar must be notified at N/A Baltimore X☐Yes 2☐No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 903 W. Barre Street 21230 U. S. A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filad wit Department of Health and Mental Hygiens Importent: If item 27 is marked other the any injury or other treumetic event. If a once. Bakery Baking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rose L. Palacorolla Joseph Vince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 426 Shipley Rd. Linthicum, MD. Michele Young, niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-18-05 New Cathedral Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on suse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (Pas a consequence) Pnysician /Medical **Examiner** NOMERS Sequentially list conditions, if any, loading to minimating cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit certificate be exacuted Due to (or as a consequence of) the attending physician thed for usa as the burial Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) No detached 9 Unknown 9 Unknow been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Vear Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29d. Date signed (Month) Day, Year) 29b. Signature and title of certifie ပ and address of person wh 200

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2005

32. Registrar's Signature

Physician /Medical **Examiner**

anding physician and use as the burial-transit

attending physi I for use as the I

signed b

filled in by the funeral director,

After

within 24 hours after death. To the Funeral Director: A

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be

To the Hospital or Attending Physician:

Examine

Physician/Medical

by

Completed

Be

Certification:

Medical

IF FEMALE:

27. Manner of Death

Natural 2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

			riease	Type of Fill	IL III DI	ack inu	elible lilk	. Elisuie A	ii cobies	AIEL	egible.	
		_ For		State of Ma	aryland	/ Depa	tment of H	lealth and N	Mental Hy	/giene	005	13241
		1 - State Registrar					ificate of			Reg. No.	. 0 0 0	10241
		1. Decedent's Name	e (First, Middle, Las	st)					2. Date of D		Vaar	3. Time of Death
Physic /Medi		L	eona M.	Webb					APril	1 Day	2005	3:55PM
Exami		4a. Facility Name (I	f not institution, give	street and number)			4b. City, Town, o	or Location of Death		4c. 0	County of Deat	h
		Franklin	n Savad	e Hospit	al Ce	enter	Rose	dale		b		nore
Funeral		5. Social Security N		ex 7.Ago □M.2√2F	e (In yrs. la:		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Aug 2,	rth a <i>y, Year)</i>	9. Birt	hplace (State or Foreign ountry)
Director		216-18-	2123	L M ZX	81	Yrs.			Aug2,	1923	Ma	ryland
Pud &	1	Usual Residence of 10a. State	Decedent 10b. County		10c City	Town or Loc	ation					10d. Inside City Limits
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8a-f	Funeral Director			21.6		; ند						
ith th	Ë	10e. Street and Nur					10f. Zip Code			10g. Citiz	en of What Co	ountry?
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e su su su su su su su su su su su su su	ne	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	. 13. W	as Decedent of H	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or N	0- 1	 Race - Ame Black, White 	
afte or It		_	ied 🏖 Married	1 ∐Yes 2 🔀 N If Yes, Give	10	i .	⊒Yes 212 No		, , , , , , , , , , , , , , , , , , , ,		Specif W hi	
ours Fal',	d by	3 🗌 Widowed	4 Divorced	Year or Dates:						`	Specify 11 1	
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ithin	npi	Elementary/Seco		College (1-4or 5	+)					Sta	te of	Maryland
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office the veni	Be ((First, Middle, Last)					18. Mother's Nam				
s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic avent, the Medical	10	Fran	k Wisner	r				Ethel	Greer	nsfel	.der	
sho ama uma	i.	19a. Informant's Na	ame/Relationship (7	Type, Print)		19b. Mailing	Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, 2	Zip Code)
and 2 ealth a n 27 l		John H	. Webb	/husband		505	North	Stuart	Street	: Bal	timor	е
es 1 and of Health of Hem 27 r other tr		20a. Method of Dis	•		CAL	netery crem.	tion (Name of story or other pla	ce)	Date		ation - City or	
permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if them 27 is marked other than any injury or other traumatic avent, ILa Magnes.			☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	Oak	Lawi	Cemet	ery 4/2	1/05	Bal	timor	e MD
permit. Departe Import any inj		21. Signature of Fu	neral Service Licen	1 1	11	22.	Name and Addre	ess of Facility CO	nnellv	Fune	ralHo	meofEssex
20 5 8 B		7 /	111111	1/1	0 1 1 1					_,		1001

300 Mace Ave. Baltimore MD 23a. Part1. Enter the disease, or combications that caused the death shock, or heart failure. List and one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest

Approximate Interval Between Onset and Death

Year

21221

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

	mansitional	cell	bladder	Cancel
	Due to (or as a consequenc	e of):		
. =				
	Due to for as a consequence	o offic		

Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗌 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 ☐Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

3 Probably

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ension nemia

25. Was case referred to medical examiner? examiner?
1 Tes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an autopsy

1 ☐ Yes

5 Pending 1 🗌 Yes investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

Bes0000

Square Drive Baltimore, MD. 21237 30. Name and address of lerson who completed cause of death (Item 23a) (Type, Print)

1) F. Youn ha Jain 900 F (anh) n

31. Date filed (Nonth, Day, Year)

32. Regist s Signature

APR 1 9 2005

State Registrar

			For State Registrar	State of Ma	arylan	d / Depa	artmen rtificate	t of H	ealth a	and M		jiene () eg. No.	05	13242
	Physici	312	Decedent's Name (First, Middle, Las								2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Merle D.				T				APRIL	T	005	8:54a ™
	Examin	er	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death	å	4c. Cour	nty of Death	
_	Funnant		Morningside House 5. Social Security Number 6. Se	7 An	lship) last birthdav)	If Under	nov 1 Year	or If Under	24 Hrs.	8. Date of Birth		e Aru	ndel pplace (State or Foreign
	Funeral Director		225-18-6452	_м Ж ⊒ғ	84	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day APR 23	1920	Vi	rginia
	P		Usual Residence of Decedent											
	show	<u>_</u>	Maryland Anne Ar	undol	10c. Cit	y, Town or Lo		anove	ar.					10d. Inside City Limits 1 ☐ Yes 2 Z No
	Ne M	ectc	10e. Street and Number	under								0.000	(14/1 0	
	with i	급		wanh Daad			10f. Zip	Code	2107	6	'	0g. Citizen o		antry ?
	ms 23	era	7548 Old Teleg	12. Was Decedent I	Ever in U.	S. 13.	Was Deced	lent of Hi			ecify Yes or No- Rican, etc.)		ace - Amer	ican Indian,
9	or Ital	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📆 N	lo		If Yes, spec 1 ☐ Yes 2				Rican, etc.)	1	llack, White cify: Wh	
5-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-1 show itsul Exartires I rust Le rediffed at	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 195 4	ZIM NO	Specify:			Spec	city: VVII	110
15-("netu	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	k done	ation Juring mos	t of worki	ng	16b. Kind of		ndustry te and
2121	withir ene. then	dimo	Elementary/Secondary (0-12)	College (1-4or 5	+)		okkeer		,				truct	
d	e filed Hyg other	Be C	17. Father's Name (First, Middle, Last)				JARCOF		18. Mothe	er's Name	(First, Middle,			
/lar	uld be Menta Irked Itic ev	To B	Byron Deale						S	alli	e Jenki	ns		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Department of Healine 21 is marked other than "naturel" or itams 23a or 28e-1 show any injurtor or other traumatic event, the Medical Examinating must be notified at once.		19a. Informant's Name/Relationship (7 Carolyn Byers/dau								t Ellic			
ē,	f Hea item		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	osition (Nam	ne of	a)	С	ate	20c. Location	n - City or T	own, State
E G	Page nent o ant: If Iry or		1 ☐ Burial 2 XXCremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			ro Cre				4/1	9/05	Balti	more,	MD
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7	/Medical		disease or condition resulting in death)	a. Due to (or as		uence of):	D			Car				-sym
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687	ificate g phys	edlc		d										
Box	leath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			TEstania ar	0000000				23d. [Date of deliv	very
. B	deatl	slcia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐ Pregnant at			☐Ectopic pre☐Other (spe					1	Vonth	Day Year
P.0	that the de ned by the a detached t	Phy	9 Unknown											
S,	res th	by	Part II. Other significant conditions co	ontributing to death bi	it not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to			the cause of death?
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Records,	sicien: The law s certificate has b lirector, page 2 s	Completed									24a. Was a autops perform	v	 Were aut prior to condeath? 	opsy findings available ompletion of cause of
	n: Th ficate or, pag		OF Man anno referred to medical								1 Yes	2/2 No	1 🗌 Yes	2□ No
Vital	Physicien: this certificanal director,	o Be	25. Was case referred to medical examiner?	Hospital:	nt 2 🗆	ER/Outpatier	nt 3 🗆 DO	Othe			Check only on		thor /Case	Assisted _{My} Living
	g Phy er this eral c	\vdash	27. Manner of Death	28a. Date of Injui (Month, Da)		28b. Time o		8c. Injury Work			28d. Describe ho			(y) LIV 1113
ion	Attending F death. ctor: After y the funera	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		r rear)	Injury	М		res 2 🗆	No				
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	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ledical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 10 Medical Example 11 Medical Example 12 Medical Example	/sician: To the best of iner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my of	ie, date an pinion, dea	d place, a th occurre	and due to the ca ed at the time, d	ause(s) and i ate and place	manner as : e, and due !	stated. to the cause(s)
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	5		30. Name and address of person who can SRIDIMR ATLUR	completed cause of d		23a) (Type,	Print) Hig	hwi	ry,	Parci	ideur,	MD 2	1122	
	Sta	te ar	31. Date filed (MAPPRBY, 1°9) 20	Registra	ır's Signa	ture	1		7/		-			

			State of Maryland / Department of Health and Mental Hygiene 0 5 1 3 2 4 3 1- State Registrer Registrer Certificate of Death Reg. No.
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year April 14 265 1/-10 PM
	/Medic Examir		4a. Fadlity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Tyrs. 7. Age (In yrs. last birthday) Tyrs. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min.
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	h the Ma r 28a-f s	Funeral Director	109. Street and Number 101. Zip Code 10g. Citizen of What Country?
	leath wit ns 23a c	eral D	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, if a Madical Eventing Ite ricitified at ance.	by	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-American Indian, Black, White, etc.) 1 Never Married 2 Married 1 M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 N Yes 2 No Specify: Sp
Maryland 21215-0036	in 72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
1212	iled with tygiene. her thar nt, the	Comp	Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Restricted Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
ylanc	should be find Mental H s marked of umatic ever	To Be	Unknown Josephine Wirtherington
	and 2 sho balth and n 27 Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or "ural Route Number, City or Town, State, Zip Code 2 10317 Googe town Blvd. Apt. A., Sickes VIIIe MD
altimore,	Pages 1 avent of Hea nent of Hea int: If item iry or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery or other place) 20c. Location - City or Town, State
altin	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility VORK RD, TIMONIUM MD 2109
8	89 1 2 8		23a. Part1. Enter the disease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
3	Pnysician		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Onset and Death Onset and Death Z // A // C // C // C // C // C // C //
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8760,	cate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last Due to (or as a consequence of):
9	rtificate be ex ng physician s as the buria	Medical	IF FEMALE:
.O. Box	The law requires that the death certificate be execuled the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No
<u>a</u>	w requires that the de been signed by the a should be detached	by Phy	9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ords	require been sig should b	eted b	DEEP Vein Thrmbasis, let leg; lygertension 1 Yes 2 No 3 Probably 4 Denknown
Vital Records,		Completed	24a. Was an autopsy findings available prior to completion of cause of performed? 1
Vıta	s certifical irrector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No
on of	ing Phy After this uneral d	lon; To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending 28b. Time of Injury Work? 28c. Injury at Work?
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) M 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)
_	Hospital 4 hours a Funeral [edical Ce	29a. Certifier (Check only (Check only and due to the cause(s) and manner as stated. (Check only (Check only and due to the cause(s) and manner as stated. (Check only (Check only and due to the cause(s) and due to the cause(s) and due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			Marcios GALicia, m.D. 3900 Loch Raven Boulevard & Baltimore Md. 21218
	411		MARIOS GALICIA, MD. 3900 Loch Raven Boulevard & Baltimore Md. 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Sta Registr		APR 1 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Nance 11:31 2005 April -1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2 F Months 3 Yrs. 213-50-236 Director 0-10-1951 MARYL Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other traumatic event, I'm Medical Exacting intuit be rediffical at Cockeys vill 1 Yes 2 No Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number USA 11022 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced white. Baltimore, Maryland 21215-003 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ DICER Kau mond Komaine J 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematery of other place) 11 20a. Method of Disposition

1 □ Burial 2 Coremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) 20c. Location - City or Town, State vans Funeral Chapel-4-20-05 Forest Hill 22. Name and Address of Facility YORKKD, TIMONIUM MD 21093 21. Signature of Funeral Service ALTERNATIVES FUNERAL+CREMATION CTR Dunkel autolky 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Nhknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2XN has certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ို 1 Inpatient SER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Box 68760 P.O. of Vital Records, To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Division

29d. Date signed (Month, Day, Year) 29b. Signatur who completed cause of death (Item 23a) (Type, Print) N. Charles St Baltimore, Mo 21204

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2005

2. Registrar's Signature

amend item/160 Derrit in Black indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 14, 2005 Pear **Physician** 11:30 P M WEINSTEIN HARRY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** LORIEN NURSING HOME COLUMBIA HOWARD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**⊋**M 2□F Months Days Hours Yrs. 101-03-3567 Director 94 09/10/1910 N.Y. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits treumetic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5320 DORSEY HALL 239 21042 DRIVE APT. #106 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No by 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Garment MECHANIC GARMET 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of MORRIS WEINSTEIN MARY **EPSTEIN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other tree JANET EPSTEIN/DAUGHTER 10532 JASON LANE COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If eny injury or once. * 4 □ Donation 5 □ Other (Specify) COLUMBIA MEMORIAL PARK 04/17/2005 COLUMBIA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Molace 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PANGRATIC Immediate Cause (Final **Physician** TUMOR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes No ^L 1 Inpatient 2 ER/Outpatient 3 DOA Months → Market → Ma 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 ☐ Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 12 d cause of death (Item 23a) (Type, Print) Columbia, Mo 5450 edman 32. Registrar's Signature

State Registrar

		1 - For State Registrar 4-6-05 Ame 1. Decedent's Name (First, Middle	, Last)	D.FG. C	1	rtificate			2. Date of De			3. Time of Death
hysicia /Medic		Walter Fred B	Bryan						March	30, 2	.005	9:15 p
xamin		4a. Fecility Name (If not institution		er)		4b. City, To	own, or Lo	ocation of Dea		1	unty of Deat	h
		Montgomery Ho	spice				kvil			Mo	ntgom	ery
neral		5. Social Security Number	6. Sex 7.	Age (In yrs. I	last birthday) Yrs.	If Under 1		If Under 24 Hr Hours Mir	n. (Month, Da	th By, Year)	_ Co	hplace (State or Foreignuntry)
ector		226-74-9080 Usual Residence of Decedent	21						Apr. 2	2, 195	I Ga	lax, Virgi
MOW THE		10a. State 10b. County			y, Town or Lo							10d. Inside City Limit
Liffied	ctor	MD Prince	e George		Mitche	llvill	e 					1 XYes 2 □ N
important: if item 27 is marked other than "natural, or items 23s or 28s-1 show any injury or other traumatic event, Its Madical Examinar must be notified at once.	Funeral Director	10e. Street and Number 11030 Spyglas	ss Hill Cou	rt		10f. Zip C	^{ode} 0721			10g. Citizen	of What Co	ountry?
E E	nera	11. Marital Status	12. Was Decede Armed Force		S. 13.	Was Deceder	nt of Hisp	panic Origin? (Specify Yes or No into Rican, etc.)	o- 14.	Race - Ame Black, Whit	rican Indian,
T T	Fu	1 ☐ Never Married 2 💢 Marri			ĺ	1 ☐ Yes 2 ☐		Specify:	into Hitani, etc.,			lack
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is marked other than "natural, or items sumatic event, It's Madical Exempler my	Completed	15. Decedent (Specify only highes	t grade completed)		16a. Dece (Give life.	dent's Usual (kind of work of DO NOT use	Occupation done dur retired)	on ring most of w	orking	16b. Kind o	of Business/	Industry
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othe /ent,	Be C	17. Father's Name (First, Middle, I	Last)				18	8. Mother's Na	ame (First, Middle	, Maiden Sur	mame)	
tic e	ToE	Rudolph Bryan						Madel:	ine Edwar	rds		
aums		19a. Informant's Name/Relationsh							Rural Route Numb			
m 2/ her tr		Idonia Bryan/	Wife	20h D			_	s Hill				MD 20721
or of		20a. Method of Disposition 1				osition (Name matory or othe		4.7	Date			Town, State
njury		'4 □ Donation 5 □ Other (Sp		Res				ery 4/	5/05 Strickla	Clint		
any ir	y 13	21. Signature of Funeral Service	icensee	1 west	I				d, Camp S			
		23a. Part1. Enter the disease, or	complications that cause	sed the death							-,	Approximate
ician	8 V	shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each	n line.	Ce	SLON	0	reev				Interval Between Onset and Death
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attending pri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth			DEctopic preg	nancv			23d.	Date of del	
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200	þ	Part II. Other significant conditio	ns contributing to death	n but not rest	atting in the u	nderiying cau	se given	in Part I,		Yes 2 N		the cause of death?
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irector, page 2		25. Was case referred to medical							1 ☐ Yes	2 PNo	1 🗆 Yes	
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funeral d	}	27. Manner of Death	28a. Date of I	njury	28b. Time o		Injury at		28d. Describe			n re ice
2 5	atlo	1 Natural 5 Pending 2 Accident investig		Day Year)	Injury	М	Work? 1 ☐ Yes	s 2 🗆 No				
. e	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	Injury - At ho		reet, factory, o	office		28f. Location (: City or Tox		umber or Ru	ıral Route Number,
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completely filled in by the fu	edical	one)	86_	of death (Item	23a) (Type	Print)	200	41119			04	±303

State of Maryland / Department of Health and Mental Hygiene 15

4-1-05

Bornstein, marjorie

1- For State of Maryland / Department of Health and Mental Hygierie 0 5

Certificate of Death Reg. No.

13249

			- Hegistrar				timouto or	Douth			eg. No.				
	Physici /Medic		1. Decedent's Nam <i>e (First, Middl</i> e, La Melvin	L.	Becl	ker				oate of Dear Month arch	th 30, 200	Year	3. Time of Death 8:57 P.M		
	Examir		4a. Facility Name (If not institution, give street and number)				4b. City, Town,	or Location of D	eath		4c. County of Death				
			Holy Cross Hospital					ver Spr	ing		Montgomery				
	Funcion				(In yrs. last	birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			ate of Birth			place (State or Foreign		
	Funeral Director			1 ∑ M 2□F	70	Yrs.	Months Days	Hours M	Vin. (/	Month, Day	Year)	Cou	nington,DC		
	Director		Usual Residence of Decedent							,cpc.	7,1754	Wasi	iring con, be		
	and *		10a. State 10b. County		10c. City. To	own or Lo	cation						10d. Inside City Limits		
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	Be-f	ctc		gomery		Silv	er Sprir								
	or 2	Director	10e. Street and Number		10f. Zip Code	What Cou	Intry?								
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	dea	Funeral	11. Marital Status	12. Was Decedent B		13. \	Vas Decedent of f Yes, specify Cu	Hispanic Origin	? (Specify	Yes or No-	14. Rac	e - Ameri	ican Indian,		
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000	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or Items 23a or 28e-f show avent, it a Mydical Examinar must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1958	1	I□Yes 2⊠No	Specify:			Specify	/: Wh	ite		
ş	tura		15. Decedent's E	ducation	16	Sa. Decec	lent's Usual Occi	unation			16b. Kind of B	usiness/lr	ndustry		
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<u>a</u> <u>a</u>	d ot	Be	17. Father's Name (First, Middle, Last					Name (Firs	st, Middle, I	Maiden Suman	iden Sumame)				
<u>a</u>	Men	2	Harry Becke	er				Doro	othy I	Herson					
Mar	should be seen		19a. Informant's Name/Relationship (Туре, Print)	1	9b. Mailin	g Address (Stree	at and Number o	r Rural Rou	ite Number	; City or Town,	State, Zij	code)		
≥	nd 2 27 i 27 i		Arline Claxton/	Sister		4000	Mass. A	ve.,NW	#1604	, Was	h.,DC 2	0016			
ก	He He		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of				20c. Location -				
oanniore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other traumatic avent, the Mudical Experiment must be notified at anone.		1 Turial 2 Cremation 3								. 1 3/	Manual 1			
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			23a. Pen k Enter the disease, or com	plications that caused	the death. D	o not ente	er the mode of dy	ring, such as car	diac or res	piratory arre	øst,		Approximate Interval Between		
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	Physician /Medical		disease or condition resulting in death)	Congest:			rallure								
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=	ng P Iter t nera	ü	27. Manner of Death 1. 1. Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28t	 Time of Injury 	28c. Inju	ury at ork?	28d. l	Describe ho	w injury occur	red			
JIVISIOII	ath. r: Ai	atic	2 Accident investigation]Yes 2 □No							
<u>n</u>	Atte	1	3 Suicide 6 Could not be determined	288. Place of inju	ry - At home,	farm, stre	et, factory, office	9				er or Run	al Route Number,		
5	a afte	Certification:	- I Homicide	building, etc	. (эрвспу)					ity or Towr	i, Siale/				
	spit		29a. Certifier 1 Certifying Pl	hysician: To the best of	f my knowled	ige, death	occurred at the	time, date and ni	lace, and d	ue to the ca	ause(s) and ma	anner as	stated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Example)	miner: On the basis of and manner sta	examination	and/or inv	estigation, in my	opinion, death o	occurred at	the time, da	ate and place,	and due t	o the cause(s)		
	o thing of the control of the contro	Me	29b. Signature and title of certifier				29c. Licer	nse number		2	9d. Date signer	d (Month.	Day, Year)		
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			30. Name and address of person who				,								
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 04 2005

			1 - For State Registrar	State of	Marylan				ealth a		ental Hyg	giene Reg. No.	05	1325	50	
	Physici	an	Decedent's Name (First, Midd	·							Date of Dea Month		2 Xear	3. Time of		
	/Medic	cal	ROBERT KENN 4a. Facility Name (If not institution		harl		4h Cihi	Tour	Location		March 29 2005 2:50A Meath					
	Examin	er	500 Quaint Ac		<i>,</i>				Sprin				ontgome			
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth	 n		nplace (State o	r Foreign	
ш	Director		217.44.6400	1 🖫 M 2 🗆 F	59	Yrs.	Months	Days	Hours	Min.	Dec. 31	19	45 Da1	las, TX		
	and w		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ly, Town or Lo	ocation							10d. Inside Ci	tv Limits	
	Maryli febo	ğ		gomery	•	ilver		n Ø						1- <mark>⊠</mark> Yes	•	
	r 28a	Directo	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?					
	th with									U.;	U.S.A.					
	lems lems	Funeral	11. Marital Status	12. Was Deced Armed Forc	ent Ever in U	.S. 13.	Was Dece If Yes, spe	dent of Hi	ispanic Ori n, Mexicar	gin? (Spe	city Yes or No- Rican, etc.)	14	I. Race - Ame Black, White			
36	s afte	by Fi	1 Never Married 2 ☑ Ma 3 Widowed 4 Divorce	If Yes Give			1 🗌 Yes		Specify:				Specify: Wh			
Ş	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f ehow int, Itte Macinal Examinational be Indiffied at	edt	15. Decede	nt's Education	os.	16a. Dece	dent's Usu	ial Occupa	ation			16b. Kind	d of Business/	ndustry		
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ng ng	be fill ad oth evan	Be	17. Father's Name (First, Middle Robert Edwa									ne (First, Middle, Maiden Sumame)				
<u> </u>	hould d Mer marka matic	ဥ	19a. Informant's Name/Relation					s /Street a			Kennedy		City or Town, State, Zip Code)			
Baltimore, Maryland 21215-0036	ulth an 27 is in trau		Rita L. Bell/V				-				, Silve				4	
ē,	of Hear		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)							Date 20c. Location - City or Town, State						
Ĕ	Page nent c ant: If ury or		1 ☐ Burial 2 ☑ Cremation '4 ☐ Donation 5 ☐ Other (ate					3/3	1/2005	Bren	twood,	Maryla	nd	
ăait	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: It flam 27 Is marked other tt any Injury or other traumatic evant. Ill once.		21. Signature of Funeral Service	Licensee	+-	H 22	2. Name a	nd Addres	s of Facilit	y 'UNER	AL HOME	. TNO	3.			
	₫ O E @ O		Nancy A	. Vacen	M	[1]	<u> 1800 </u>	New I	Hamps	hire	Ave, S	<u>ilve</u> ı	Sprin			
н			23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final	t only one cause on each	ch line.	n. Do not ent	ter the mo	de of dyln	g, such as	cardiac o	r respiratory ari	rest,		Approximate Interval Bety Onset and D	ween Death	
	Physician /Medical		disease or condition resulting in death)	a. Metast	atic I		ncer							2 Year	:s	
	Examiner				as a conseq	puerice or).										
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	and and trans	Examiner	Cause (Disease or injury that initiated events c													
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/89	ohy:	edicai	d.													
ROX	that the death certific hed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								23d. Date of delivery					
	death	sicia	in the past 12 months? 1							Month			Day Y	ear/		
J O	at the d by th etache	Phys	9 Unknown													
Š	requires that the een signed by th nould be detache	by	Part it. Duties significant conditions continuously to death out not resulting in the underlying cause given in Part it.									Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
Kecords,		Completed	24a. Was an													
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Vital	(D)	0	25. Was case referred to medical	al					26 Place	of Death	1 Tes		1 L Yes	2 No		
	<u>S</u> . <u>⊗</u> S	To B	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 Ing	patient 2	ER/Outpatier	nt 3 D	OA Othe	ar-		ne 5 🔀 Resid		Other (Spec	ify)		
n 01			27. Manner of Death 1 ⊠Natural 5 ☐ Pend	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		28c. Injury Work	at	2	28d. Describe h	ow injury	occurred			
<u> </u>	r Attanding er death. ractor: After by the fune	cati		tigation	C. S. Charles B. S. Se		М		Yes 2 🔲		206 1 (C	**************************************	Alumbara G		h	
DIVISION	7 7 7 6	Certification:		mined 286. Place of	g, etc. (Specif	ome, farm, str (y)	reet, ractor	y, office		1	28f. Location (S City or Tow		Number or Hu	rai Houte Numi	<i>jer</i> ,	
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	ha Ho in 24 t he Fu bletely	edicai		I Exeminer: On the bas and manne	is of examina											
	To t. Withi To tl	Ž	29b. Signature and title of certifi	1 -1				c. License			2		signed (Month			
	(1	funt				0-003	3293			Mar	ch 31,	2005		
)		30. Name and address of persor Frederick P.	who completed cause Smith MD	of death (Item	n 23a) (Type, 4 Wisc	Print)	a Ave	nue.	Suit	e #1300	, Ch	evy Cha	ase. MD	0001-	
	Sta	te_	31. Date filed (Month, Day, Year		gistrar's Signa	ature						, ,	, 5110	, ,	<u> 20815</u>	
	Registr		APR 0	4 2005	Acres 1	di de	act.	0								

	_	1 - State Registrar	State of N	narylar	-		nt of H		ina M	F	leg. No.	005	132	251	
Physici		1. Decedent's Name (First, Middle LOUIS JOHN		r.						2. Date of Dea Month April	Day	2005	3. Time 9:51	of Death	
/Medic Examin	ner	4a. Facility Name (If not institution, give street and number) 12516 Over Ridge Road					y, Town, or Potom	ac			4c. County of Death Montgomery				
Funeral Director		5. Social Security Number 156-14-5568 Usual Residence of Decedent	6. Sex 1 M 2 □ F	Age (In yrs.	last birthday) Yrs.	Month:	er 1 Year s Days	If Under:	Min,	8. Date of Birth Month, Day June 14	Year 19	9. Birtl Co New	hplace (State untry) Jerse	or Fore	
e-f show	ctor	10a. State 10b. County	gomery	10c. Ci	ty, Town or Lo								10d. Inside	City Lim	
e or 28	Dire	10e. Street and Number					Zip Code	E /.			-	Citizen of What Country?			
peniar. Tages I and 2 should be lied within 2 hours are bean with the waryand Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumetic event, the Medical Examinator institution and once.	by Funeral Director	12516 Over Ridg 11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? If			20854 Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:					United States 14. Race - American Indian, Black, White, etc. Specify: White				
giene. er than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ The secondary (1-4or 5+) Special Agent								16b. Kind of Business/Indu Federal Bure Investigatio			f		
Mental Hyg arkad othe etic event,	To Be C	17. Father's Name (First, Middle, L Louis John Brur	ne Sr.					Soph	ie M	ne (First, Middle, Maiden Surname) M. Seretzky					
h and 7 Is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2													
ant of Healt it: If itam 2 y or other		Nancy L. Brune 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 🛣 Other (Sp.	3 □Removal from Stat	• •	Place of Disponentery, cremetery, cremetery	sition (N	ame of other plac	e) A		5,	20c. Loca	tion - City or Ter Spr	Town, State	ſd.	
Departme Importan any injur once.		21. Signature of Funeral Service L		iic ou	22	. Name	and Addres	s of Facility	Del	Vol Fune r. Gait	ra1	Home			
nysician Medical xaminer		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each only one cause on each only one to (or a	line. G	ANC		2	g, such as	cardiac o	r respiratory arr	est,		Approxima Interval Be Onset and	etweer	
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ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								236	23d. Date of delivery Month Day Year				
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certifi	o Be	25. Was case referred to medical examiner?	Hospital:		155/0	• • • • • • • • • • • • • • • • • • • •	Othe	AF:		(Check only on					
eath. tor: After this certificate ha the funeral director, page	$\vdash \vdash$	1 Yes Ye					28c. Injury Work	4 Nui	rising Home 5 esidence 6 Other (Specify) 28d. Describe how injury occurred No				ify)		
within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director.	Certification:	a Clouded the Could get be							treet and Number or Rural Route Number, n, State)						
within 24 hours after c To tha Funaral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manner:	of examina	owledge, death ation and/or in	occurre restigation	d at the tim	e, date and inion, deat	l place, a h occurre	nd due to the card at the time, d	ause(s) ar ate and pl	nd manner as ace, and due	stated. to the cause	(s)	
within 2 To tha	Σ	29b. Signature and title of certifier	4 MET	-7	MD	2	9c. License		00	2	9d. Date s	igned (Month	Day, Year)		
2 ' '		30. Name and address of person v						-	-				208	73	

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	Physici	an	1. Decedent's Name (First, Middle	, Last)	_				2. Date of De		Yeer	3. Time of Death			
	/Medic	cal	As Esciliby Name (If not institution		11 A. Br	ashear		Lastin (D.	April	4 2	2005	7:10a ^M			
	Examir	ıer	er 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hosptial Rockville							4c. Count	y of Death				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bir in. (Month, Da	th Voor	9. Birth	gomery place (State or Foreign			
ļ.	Director		212-22-1847	1∰M 2□F	79	Yrs.	Moritins Days	Hours M	Jan. 2	1926		yland			
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits			
	a-f sh	ctor	Maryland Frederick Monrovia									1 ☐ Yes 2 ☒ No			
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?			
	eath w	Funeral Director	11965 Gladhill			16 1401		1770	(0)		United States				
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Marr 3 🏧 Widowed 4 □ Divorced	Armed F	2 🔀 No ive	1	Was Decedent of H f Yes, specify Cuba ! ☐ Yes 2☑ No	Ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Speci	ce - Ameri ack, White, fy:	etc.			
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a	2 should and N	۲	Guerney E. Brashear Ada L. Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
S S	and and lealth m 27		Rebecca Farmer/	Daughter			West Fall	ls Road				21771			
	ages 1 of F or of		20a. Method of Disposition 1 ③Burial 2 ☐ Cremation		State	cemetery, cren	sition (Name of natory or other place	- 14/	7 / 2005	20c. Location	· City or To	own, State			
	nit. Pa artme ortant injury		'4 ☐ Donation 5 ☐ Other (S) 21. Signature of ☑ neral Service i	• •	Bet		Methodist	: Cemete	ery	Damascu		ryland			
Ö	Dep Imp		Lodd 1	HILIN	1	0 T	Name and Addressin L. Mol 401 Ridge	lesworth Road	n P. A. F	uneral	Home	0872			
	100		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ente	er the mode of dying	g, such as cardi	iac or respiratory a	rrest,	- Carret	Approximate Interval Between			
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5	ding th: : After s funel	tion	1 Natural 5 Pending 2 Accident investig	(Mor	th, Day Year)	Injury	28c. Injury Work M 1 🗀	at ?? fes 2 □ No	28d. Describe i	now injury occur	red				
2	r Atter ter dea irector ir by the	Certification:	3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num City or Town, State)								oer or Rura	l Route Number,			
3	pital c		29a. Certifier 1 Certifying	F											
	To the Mospital or Attending Physicien: The law within 24 Hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	l edical	one)	Physician: To the examiner: On the band man	asis of examina ner stated.	tion and/or inv	estigation, in my op	inion, death oc	curred at the time,	date and place,	and due to	the cause(s)			
	To To Con	Σ	29b. Signature and title of certifier	of-			29c. License			29d. Date signe					
	4		30. Name and address of person	who completed cau	se of death (Item	1 23a) (Tuna 1	Print)	41162		17 6 21	14	200)			
	U		1. Canti	6791	CI D	oct	cvi Di	9111	Genn	rante	no N	2005			
	Sta Registra	- 4	31. Date filed (Month Par Year)	2005 32.	gistrar's Signa	ture	lock!								

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 8:00 A M Shirley P. Blaney April 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4330 Linthicum Road Howard Dayton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 3, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 217 56 3209 Maryland Director 62 1942 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Exempter must be mutilied at 1 ☐ Yes 2X No MD Howard Dayton Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4330 Linthicum Road 21036 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 █XNo Specify Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fited withtr Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve Charles D. Craver Viola I. Yeager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony P. Blaney/Son 15520 Cattail Oaks Glenwood, MD 21738 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State St. Louis Cemetery 4-7-2005 Clarksville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee () MO1044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) mol 9191t SCIEDON. **Physician** 20C 00 15 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner -transit certificate be executed and Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ▼ No detached 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 cate has been signage 2 should b 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 XNo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 1 ☐ Yes 2 📉 No 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: Injury the Hospital or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🕉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies D3312 April 5, 2005 Taubman and Edward cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed BINCO SHILD Olne Da 31. Date filed (Month 32. Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2005 Frederick S. Beckley April 6:30 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Howard Howard County General Hospital Columbia If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 14, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** XnM 2□F 214 22 3209 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2X No Director MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4717 Middle Court 21043 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Yes, Give Year or Dates: WWII 1 Yes 2 No Specify. Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Art Director Belsinger Sign Co. traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental P Edna Myers Frank Beckley 2 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 4717 Middle Court Ellicott City, MD 21043 Elizabeth J. Beckley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 4-7-2005 Catosnville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Ligensee MO1044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 □ No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? 2 No certificate 1 ☐ Yes 2 X No 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2X ER/Outpatient 3 DOA ည this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certification: After To the Hospital or Attending 5 Pending investigation 1 Natural М 1 Yes 2 No death. 2 Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Yno April 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 55732 mp 6565 N. CHARLES ST #203 BALT MD 32. Pagistrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygierie (

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 35 **Physician** AM 2005 /Medical Winton Irvine Burger I

4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 12927 Point Salem Road
5. Social Security Number 6. Sex 7. Hagerstown
If Under 1 Year | If Under 24 Hrs. | 8. Date of Washington County 6. Sex 1**XOX**M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. Hours Vrs 214-09-5482 91 Director April 10 1913 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturst," or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine must be notified at any injury or other traumatic event, the Medical Evantine must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12927 Point Salem Road 21740 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0020 1 ☐ Yes 2 Ho Specify: Specify:White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Pete's Moving & College (1-4or 5+) Owner Transfer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Charles Burger Frances Ward Burger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian C. Burger (wife)
20a. Method of Disposition 12927 Point Salem Road Hagerstown Maryland 21740

20b. Place of Disposition (Name of cametery, crematory or other place)

20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem Park Apr 5 05 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart finure. List only one cause each line. Approximate Interval Between Onset and Death **Physician** ATHENOSCHOOZW Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificete be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 Tyes 2 No 3 Probably þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes 1 TYUS 1 TYUS 2 TNo certificete Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: , 2 No 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mann of Death Director: After thi I in by the funeral Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a edical 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medica (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month. Dav. Year) and title of certi D56783 2005 o commeted cause of death (Item 23a) (Type, Print) 54-13 Jeffrey MD 11110 Medical Campus Rd Hagerstown Maryland 21742 Hurwitz

32. Registrar's Signature

State Registrar 31. Date filed (Month)

6

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** COATES MARCH 30,2005 36 HELEN CONNOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CHEVERLY

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. PRINCE GEORGE HOSPITAL PRINCE GEORGE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ Director 197-18-7535 7,1918 VIRGINIA 86 NOV. Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. Health and Mental Hygiene. Gen 27 is marked other then "naturat", or items 23s or 28e-1 ehow then traumatic event, it is Medical Examine munitor indifficula. 1 Yes 2 No Director PRINCE GEORGE SEAT PLEASANT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 1205 CHAPEL OAKS DR. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify BLACK 3 Widowed 4 Divorced 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 JOSH_CONNOR ROXIE DABNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Old Colony Dr. S SOUTH Marlboro MD PAULA ALLEN (DAUGHTER) Upper 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 4/4/2005 Metropolitan Crematory Alexandria. VA 22. Name and Address of Facility

Cedar Hill Funeral Home 21. Signature of Funeral Service Licensee Mary E Helgman 4111 Pennsylvania Ave. Suitland 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Immediate Cause (Final disease or condition resulting in death) ATAL ARRHYTHMIA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physicien for use as the buria Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 □ No 1 Yes 2 No To the Hospitet or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 2 X ER/Outpatient 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 2 Accident 24 hours after deat Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

3001

32. Registrar's Signature

HOSPITAL

CHORGE

C. DONALD

31. Date filed (Month, Day, Year)

APR 0 6 2005

			1 - For Unpend Item Registrar	23a&27 per	aryland/Dep r me G843 Ce	artment of F 0-16-05 to rtificate of	lealth ai Death	nd Mental I	Hygien Reg. N	20 05	13257
	Physici	an	Decedent's Name (First, Middle, La	•				2. Date o Month		av Year	3. Time of Death
	/Medi		Edward James			T		APRI]		3,2005 ear	11:12A. M
C	Examir	ner	4a. Facility Name (If not institution, given 114 OSAGE STREET	e street and number)		4b. City, Town, o	r Location of	Death	- 1	c. County of Death	
2	Funeral Director		217-06-9833	Sex 7. Ag	ge (In yrs. last birthday) 20 Yrs.	If Under 1 Year Months Days	If Under 24 Hours		, Day, Yea	r) Cou	place (State or Foreign intry) D
`)	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Marylan	jo	MD Cecil		Filebon						¥∑Yes 2 No
	r 28a-f	Director	10e. Street and Number		E1kton	10f. Zip Code			10g. C	Citizen of What Cou	intry?
	th with 23s or		114 Osage S	treet		21921				U.S.A.	•
	ter deat Itams ? Iner rau	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H	ispanic Origi	n? (Specify Yes or	r No-	14. Race - Amer	
Maryland 21215-0036	a 0 5	þ	1 XNever Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ No	Specify:	Puerto Alcan, etc.	,	Specify: Wh	
Õ	"natural",	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b.	Kind of Business/Ir	ndustry
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nd	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avant, ILALM	Be	17. Father's Name (First, Middle, Last				18. Mother's	s Name (First, Mic	ddle, Maide	en Sumame)	
<u></u>	should be nd Mental markad o	2	Edward J. Car					onna Wr			
Mar	12 sh h and 7 Is m		19a. Informant's Name/Relationship (ng Address (Street a					
45	of Health of Health litem 27 I		William Wright 20a. Method of Disposition	/Brother	20b. Place of Dispo	Oak St.	Apt.	A, Boy	nton	Beach,	FL 33435
Baltimore,	ages or of		1 🔀 Burial 2 ☐ Cremation 3 ☐		cemetery, crei	natory or other plac	· 1			Location - City or T	
i i	it. Pi		4 □ Donation 5 □ Other (Special21. Signature of Funeral Service Licer		Gilpin	Manor Name and Addres	, -	oril 18,		Elkton,	MD
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8760,	ate b hysic the bu	edical		d							
(0			IF FEMALE:								
Вох	Attending Physician: The law requires that the death certif r death. actor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	by Physiclan/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy				23d. Date of deliv Month	ery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5L	Other (specify)					
٦.	that the ded by detact	h H	Part II. Other significant conditions	ontributing to death b	ut not resulting in the u	nderlving cause give	en in Part I.	23e, D	id tobacco	use contribute to t	he cause of death?
ds	uires sign Id be					, ,					bably 4 🖄 Unknown
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Re	he fav e has ige 2	Completed						a	utopsy erformed?	prior to co	opsy findings available impletion of cause of
ta	i ician : Th certificate rector, pag	മ	25. Was case referred to medical				OC Plans	1 X Ye f Death Check on	s 2□N	lo 1 🖫 es	2 No
Division of Vital Records,	ysicia s cert direct	To B	examiner? 1X Yes 2 No	Hospital: 1 Timpatie	ent 2 ER/Outpatier	t 3 DOA Othe				6 XOther (Special	SCENE
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	To the Hospital or Attending Physician: The I within 24 hours after death. To that Funaral Diractor: After this certificate ha completely filled in by the tuneral director, page	edical	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	y sician : To the best niner: On the basis of and manner sta	of my knowledge, death f examination and/or in- ated.	n occurred at the time vestigation, in my op	e, date and printed in the death	place, and due to to occurred at the tin	the cause(s	s) and manner as s nd place, and due t	tated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License	number		29d. D	ate signed (Month,	Day, Year)
			Jaska A.S.	Leense	~ U,D	OC	ME		APR	IL 14,200	5
			30. Name and address of person who		eath (Item 23a) (Type,	Print)			1	,	
			Tasha Z GVC	enbera	M.D.		enn St	reet Ba	1timo	ore, Mary	land 21201
	Sta	te	31. Date filed (Month, Day, Year) APR 1 5 2005	/32. Registr	ar's Signature	de la company de					
5	Registr	ar	HLK T 9 5002	DECEN	No Page						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 04 02 2005 6:30 A M Frances Coulbourn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 4 Hours | Min. | June 16 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗶 F Maryland 213-14-6251 87 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Examiner must be notified at 1 Yes 2 No Directo Maryland Wicomico Hebron 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 6 with U.S.A 26760 Crooked Oak Lane 21830 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No ò Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 'natural', er than "natur. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Domestic None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stella Winder James Dashiell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) thealth item 27 i 1108 Kenosha Ave.Salisbury, Md.21801 Edith Morris (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of h
important: if its
any injury or ot
once. 1 Surial 2 Cremation 3 Removal from State Green Acres 4-9-05 Salisbury, Md. * 4 ☐ Donation 5 ☐ Other (Specify) ริกัลพ์สาร์ หนักอาการ 821 West Rd.Salisbury,Md.21801 21. Signature of Funeral Service Licenses Lewin Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner FAILURE ESPIRATORY S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months Month Year 5 Other (specify) ☐ Yes 2 12 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? peubis Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No YNEUMONIA certificate 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 V Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060515 Munn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR SHUSHURY 614 MICHMANAPAYOUL ENSTERN SHURE 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

.O. Box 68760

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Division of Vital Records,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year ('ARRILLO Month ALCARAZ **Physician** 1235 M RICHARD 2005 Apri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO HEAD CENTER DEERS HOSPITA. SALISBUR If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1177 M 2 □ F 546-36-0358 75 8/19/1929 California Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent. If a Medical Experience must be notified at 1 Yes 2 No Director Maryland Salisbury Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1801 Kipling Dr. 21801 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Army 11. Marital Status 1 ☐ Never Married 25 Married 1 ☐ Yes 2 🖾 No white Specify: Yes, Give 3 ☐ Widowed 4 ☐ Divorced Korea Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Long Haul 12 Truck Driver 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) perinit. Pages 1 and 2 should be fili Depertment of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avent Be Alfonzo Carrillo Juana Alcaraz ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Kipling Dr., Salisbury, MD 21801 Caroline C. Carrillo/wife 20b. Place of Disposition (Name of cometery, crematory or other place Maryland Veterans 20c. Location - City or Town, State 20a Method of Disposition 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State 4/8/2005 Hurlock, MD 4 □ Donation 5 □ Other (Specify) Cemetery Rame and Address of Facility
HOLLOWAY Funeral Home Professional Association
CFSP 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee 3 arric Accorded 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VASCULAR 3 days CEREBRAL **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner RS PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetel death 50 in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown s been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown EPRESSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 34C051 has autopsy performed? page 2 certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No rector. 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient ö funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 ☐ Accident Injury 5 Pending within 24 hours arter committee Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

State

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after

requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Attending Physician:

Hospital

the

Tol

altimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) APR 0 7 2005

VIRGINIA

30. Name and addiess of person who completed cause of death (Item 23a) (Type, Print)

DOBOX 2018 SALISBURY md Z1802 HANH mo cmo strar's Signature 32. Res

Registrar

MDan

April 4, 2005

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			State of Maryland / Dep	artment of Health and M rtificate of Death	ental Hygie	2000	13260
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	4	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	rás
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	1 /	8. Date of Birth (Month, Day, Ye	9. Birthp	place (State or Foreign
	Director		143-20-2703 76			7, 1928 New	
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation		1	10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	Citizen of What Cour	ntry?
	th with		17416 Plantation Road	23417		USA	
	r dea	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 Married 1 ☐ Yes 2 To No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	.te
21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mantal Hygiene. It and Mantal Hygiene. ?? is marked other than "neturel", or items 23a or 28a-f show treumatic event. Its Woolcal Examinating to collified at	edt	15 Decedent's Education 16a Dece	edent's Usual Occupation	161	o. Kind of Business/In	dustry
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nd	be file tat Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Sumame)	
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Maryland	d 2 sh th and 7 is n treun			ing Address (Street and Number or Rura 5 Plantation Road,		*	
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Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 eny injury or other ODGS.		Lake Ceme	etery 04/09. 2 Name and Address of Facility Holloway Funeral Ho	/2005 La	kewood, Ne	w Jersey
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	/			
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S. I.	at the dea by the at tached fo	/sici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 9 Unknown	Other (specify)		WOTH	Day Toal
€ 4 °C	or Attending Physicien: The law requires that the death certifuler death. Director: Affer this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
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E tal	sicien: The certificate h	e C	25. Was case referred to medical	26. Place of Death	(Check only one)	No 1 Yes	2L No
	Physici this cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Hon	ne 5 🗆 Residenc	e 6 Other (Specif	y)
SIS II	h. Affer th fur eral	:uo	27. Manner of Death 1	of 28c. Injury at 2 Work?	28d. Describe how		
300	death. cter: A y t e fu	ertification	2 Accident investigation	M 1 Yes 2 No			_
일을 iN	or At offer d Direct in by	rtiff	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura Rate)	ul Route Number,
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of ceptings	29c. License number		Date signed (Month,	Day, Year)
	3		I ald Visus	HO059368		4/4/65	
	S		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Colichum 1012 2	1800		
	77		31. Date filed (Month, Day, Year) 32. Soistrar's Signature	1 SCHSTIVITY PILLE	7		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 2005 32. Agistrar's Signature	St Schishung MID 2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registra Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 10:05^{p м} 2005 Caruso April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Year) 1 ☐ M 2 🖾 F 1911 93 Massachusetts Director 578-38-4914 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28e-f show or other traumetic event, the Medical Examiner must be notified at 1 Yes 2 XNo Maryland Director Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with to and Mental Hygiene.
is marked other than "natural", or Itams 23s or 2 6512 8th Place 20783 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2K No 1X Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Office Manager Bakery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alfio Caruso Maria Nevaria 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Department of Health a Importent: If item 27 is eny injury or other tree once. Louis Caruso/ Brother 6512 8th Place, Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 5, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 2005 ¹ 4 □ Donation 5 □ Other (Specify) Washington, DC Prancis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Ryws 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician DIVAL disease or condition resulting in death) /Medical Due I (or a consequence of) Examiner Sequentially list conditions e to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as JE FEMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ģ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Hospitel or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide

Box 68760. P.O. Records, Division of Vital

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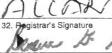
29a. Certifier

30.

Medical

31. Date filed (Month, Day, Year) 2005 04

29b. Signature and title of certifier



and manner stated

ss of person who completed cause of death (tem 23a) (Type, Print) R. DPINDER SING H

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

745660

29d. Date signed (Month, Day, Year)

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Registrar

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Division of Vital Records. P.O. Box 68760.

		Registrar 1. Decedent's Name (First, Middle, I	Last)	- 06	rtificate	01 2	Jeann		2. Date of De			3. Time of Death
icia		ROSA LEE	DANCE-LYONS						APRIL	Day	Year 2005	7:03 PM
dica nine		a. Facility Name (If not institution, g			4b. City, 1		Location o	of Death	7,7,151		ounty of Death	
al or		227-34-6974	. Sex 1 □ M 2 ☑ F 7. Age (In yrs. 80	last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Januar		25 9. Birth Con Vir	nplace (State or Foreigi Intry) ginia
	-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
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L	D Y	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:		1 ☐ Yes 2	No X	Specify:			S	Specify: BL	ACK
		15. Decedent's		16a, Dece	dent's Usua	I Occupa	ation			16b. Kind	d of Business/l	ndustry
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,	0	LEANDER DANG	CE				COID	A C	COLEMAN			
		19a. Informant's Name/Relationship			_				al Route Numb	-		
		DR. CHARLES A. LY					S HIL		R. MITCI			
		20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3	☐Removal from State	Place of Dispo cemetery, crea	matory or ot	her plac					ation - City or 1	
	4	* 4 □ Donation 5 □ Other (Spec		RYLAND				4/8/				MARYLAND
OUCE.		21. Signature of Funeral Service Lic	ensee / /						B. JENI ANDOVEI			. номе 20785
	-	23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused the dea							-	LAND	Approximate
	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, training to minimal accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect of Due to (or a) Due to (or	quence of):	le Le	/	_	i Co				Onset and Death
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	2	Part II. Other significant conditions Diabetes Me		sulting in the u	nderlying ca	ause give	en in Part I.			obacco use		the cause of death? bably 4 Munknown
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	E	11 FOI I ONSION							auto	psy prmed?	prior to c death?	ompletion of cause of
	0	25. Was case referred to medical					26 Diago	of Death	1 ☐ Yes		1 🗆 Yes	2 X No
9	0	examiner? 1 Yes 2 You	Hospital: 1 Monpatient 2] ER/Outpatier	nt 3 🗆 DO	A Othe	\F:		me 5 ☐ Resi		□Other (Spec	ify)
	Tion:	27. Manner of Death 1 → Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Bc. Injury Work	at		28d. Describe			
17.7	Certification;	3 Suicide 6 Could not determine		iome, farm, sti fy)	reet, factory,	, office	-		28f. Location (City or To		Number or Ru	rai Route Number,
	dical c		Physician: To the best of my known aminer: On the basis of examination and manner stated.									
	ĕ Z	29b. Signature and title of certifier		0	29c.	License	number			29d. Date	signed (Month	, Day, Year)
		1 DE	2/0 >1	gl		D	4566	0	The state of the s	4	1-2-0	25
		30. Name and address of person wh	no completed cause of death (Item	m 23a) (Type.	Print)							
		30. Name and address of derson wt	no completed cause of death (Ite) 143 00 Gallan	T Fox L	Print) N, St.	124	BOW	e N	10 20	115		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5

			For State Registrar		artment of Health a ertificate of Death	na mentai Hy	Reg. No.	5 13263
	Physicia	an	1. Decedent's Name (First, Middle, Last) David Grant DeGroff			2. Date of De Month	Day Y	3. Time of Death
	/Medic Examin	al	Ia. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		28,2005 4c. County of	4:35A M
		Ŭ.	Joseph Ritchie Hospice C		Baltimore			
	Funeral Director		055-60-3165 ¹X™ 2□F	e (In yrs. last birthday, 41 Yrs.	If Under 1 Year If Under 2 Months Days Hours	8. Date of Bil Min. (Month, Di June 7	th ay, Year) ,1963). Birthplace (State or Foreign Country) New York
	yland yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	e Mar	Director	Virginia	Alexana				1 X Yes 2 □ No
	with th	Dire	10e.Street and Number 3201 Landover Street,#141	Q	10f. Zip Code 22305		10g. Citizen of Wh	at Country?
	death ms 23 r mus	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No		American Indian, White, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.	by	Never Married 2 Married 3 Widowed 4 Divorced Affiliate Forces: 1 Yes, Give Year or Dates:	lo	1 ☐ Yes 2 X No Specify:	ruento nican, etc.)	Specify:	White
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	edent's Usual Occupation e kind of work done during most DO NOT use retired)	of working	16b. Kind of Busi	ness/industry
212	12 should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, the Mes	ошо	Elementary/Secondary (0-12) College (1-4or 5	ı+1 l	Graphic Artist		Printing	3
Pu	be filed tal Hyg d othe	BeC	17. Father's Name (First, Middle, Last)			r's Name <i>(First, Middl</i> e	, Maiden Sumame)	
ryla	d Men marke	2	Jacob DeGroff 19a. Informant's Name/Relationship (Type, Print)	19h Mai	Enid	Heath	ner City or Town St	ate Zio Code)
	nd 2 saith an 27 is i		William E. Milan(friend)		1 Landover St			
35 Am Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra pncg.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State		osition (Name of ematory or other place)	Date	20c. Location - C	
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Ba Ba	permit Depar Impor any in		> / Delost	7)	205 BelleHaven			
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ic cirrhosis			NIYear
3 1	Examiner		Due to (or as	a consequence of):				
5	p t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Under/tyng Cause (Disease or injury	a consequence of):				
8.	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	that initiated events c.	a consequence of):				
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rof ds, P.	w requires that the d been signed by the should be detached	d by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause given in Part I.			ute to the cause of death?
>69 C	The law req	Completed					omed? pri	ore autopsy findings available or to completion of cause of ath? Yes 2 No
Vital	ysician: The lavis certificate has director, page 2	Be Co	25. Was case referred to medical		26. Place	of Death (Check only	-	165 202110
→) >	S 10	2		ent 2 ER/Outpatie		rsing Home 5 Res	idence 6 Other	
)/(c	ding After fune	tion	27. Manner of Death 1	y Year) 28b. Time Injury	or 200. Injury at Work? M 1 ☐ Yes 2 ☐ N		now injury occurred	
Divisio	after death. I Director: A	Certification;	a D Could not be	ury - At home, farm, s c. (Specify)	treet, factory, office		(Street and Number wn, State)	or Rural Route Number,
!	Hospita 4 hours Funeral	edical C	29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of and manner str	f examination and/or i				
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed ((Month, Dey, Year)
	2		· UVO VA)	leath (Itam 20-) (T	D2417	70	March 2	8, 2005
			30. Name and address of person who completed cause of defectively 1	Hospice S	738 NEutaw	St Bal	Grove, N	10 21201
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 4 2005	ar's Signature	29c. License number D2417 3. Print) P38 N Eutaw			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** William Charman Delaha 2005 1430 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester General Hospital Dorchester If Under 1 Year If 8. Date of Birth (Month, Day, Year) Oct. 19, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2**M 2□F Days Hours 216-14-9494 81 Director 1923 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28a-f show 1 ☐ Yes 2 No Director MD Dorchester Cambridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3633 Linkwood Drive 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 □ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 postal clerk U. S. government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 le markad oth Be (William Oscar Delaha Marian Dean 0 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Linkwood Dr., Cambridge, MD 21613 Catherine Mooney daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 4/7/05 Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Brink Blun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Squamous Cell Covinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed by the second 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 27. Manner of Death 28a. D te of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident

Division of Vital Records, P.O. Box 68760, Director: filled in by

6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State

Registrar

Medical

Eric J. Widmaier DODG1822

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

M.D.

503 Byrn St., Cambridge, MD 21613

31. Date filed (Month, Pay Year) 6

within 24 hours a To the Funeral I

			State of Maryland / Department		Mental Hy	giezen 05	13265
			Registrar Certificate	of Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Month	Day Year	5:45 P. M
	/Medic		Bernard Epstein 4a. Facility Name (If not institution, give street and number) 4b. City, 7	Town, or Location of Death	March	30 2005 4c. County of Deat	h
	Examin	er	Summerville at Potomac Assisted Living	Potomac		Montgome	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		8. Date of Birt (Month, Da		hplace (State or Foreign untry)
	Director		148 10 8116 X Yrs. 84 Yrs.	Day's Floure IIIII.	August	10 1920 Ne	w Jersey
	and *	}	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f sho	ō	Maryland Montgomery Potomac				1 X Yes 2 □ No
	28e-	rect	10e. Street and Number 10f. Zip	Code		10g. Citizen of What Co	ountry?
	38 or		11215 Seven Locks Road	20854		USA	
_	within 72 hours after death with the Maryland ene. Then "naturel", or Items 23e or 28e-f show he Madical Examinat must be inclilled at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. If Yes, spec	ent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
0500-c	urel', or	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:			Specify:	White
<u> </u>	n 72 l	Completed	life. DO NOT us	k done during most of worl	king	16b. Kind of Business/	industry
7	withi iene. then	dwo	Elementary/Secondary (0-12) College (1-4or 5+) Universi	ty Professor		Education	1
0	filed Hyg other	Be C	17. Father's Name (First, Middle, Last) 5+			Maiden Sumame)	
yland	uld be Menta irked	To B	Issac Epstein	Sophie	Goldenb	erg	
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23e or 28e-f show miniprored in the properties of the proper	6 18		(Street and Number or Ruen Locks Rd.,			Zip Code)
Je,	s 1 au of Hea item		20a. Method of Disposition 20b. Place of Disposition (Nam cemetery, crematory or of	ne of ther place) Marc	hate 30	20c. Location - City or	Town, State
Ĕ	Page nent ent: If		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) George Washing		005	Washington	DC
Baltimore,	permit. Departr Importe any inji		18/14 CC			Mortuary Se	ervices
	*		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	e of dying, such as cardiac	or respiratory a	rest,	Approximate Interval Between Onset and Death 2 Years
	Pnysician /Medical		disease or condition resulting in death) a. — Definentia ue to for as a consequence of):				2 10015
	Examiner		Sequentially list conditions, b. But to (2000 2000 2000 2000)				
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_	icate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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ROX	death certific e attending p id for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (sp.			23d. Date of de Month	ivery Day Year
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ρ, J	ss tha gned se del	by P	Part II. Other significent conditions contributing to death but not resulting in the underlying of	ause given in Part I.		obacco use contribute to	
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Records,	has has	Completed			24a. Was autop perfo 1 ☐ Yes	osy prior to death?	utopsy findings available completion of cause of
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0	ding Ph h. After th funeral			8c. Injury at Work?	28d. Describe	now injury occurred	
S 10	eat or:	catl	2 Accident investigation M	1 ☐ Yes 2 ☐ No	ORA Lacation /	Street and Number or Ri	ural Dauta Alumbar
Division	of or Attendate death I Director:	Certification:	4 Homicide determined	, office	City or To	vn, State)	arai noute ivamber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check-only one) 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, in my opinion, death occu	, and due to the rred at the time,	cause(s) and manner as date and place, and due	s stated. a to the cause(s)
	To the Within To the	₩e	255. 98.437	License number		29d. Date signed (Mont	
)			Man	D28656 		March 31,	2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 8609 Second Avenue #40		Spring,	MD 20910	
	Sta Regist		31. Date filed (Month, Day, Year) APR 04 2005 32 Registrar's Signature				
		-					

			For State Registrer	State o	f Maryla	and / Depa <i>Cei</i>	artment <i>rtificate</i>			ınd Mei		giene Reg. No.	05	3266
	Physici	an	Decedent's Name (First, Midde Jerome Delma		C 20						Date of Dea Month	ath	005 Year	3. Time of Death
	/Medio	al	4a. Facility Name (If not institution	on, give street and nu			4b. City, T	own, or Lo	ocation of		arch 2		County of Death	4:15pm ^M
			Holy Cross F 5. Social Security Number	lospital	7 Age (In v	rs. last birthday)	Sil	ver	Spri:		Date of Birt		ontgome	·
ı	Funeral Director		499-09-5858	1 → M 2 □ F	7. Age (m y)	86 Yrs.			Hours	Min. A ₁	(Month, Da	8, 19	18Musko	lace (State or Foreign litry) gee, Okla.
	yland		Usual Residence of Decedent 10a. State 10b. Count	/	10c.	City, Town or Lo	cation						1	0d. Inside City Limits
	the Mar 28a-f s	ector	Maryland Montg	omery		Silver						10- 07		1 AYes 2 No
	th with	ai Dir	1408 Casino Ci	rcle			10f. Zip C	906					en of What Cour ited Sta	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 A Ma 3 □ Widowed 4 □ Divorce	12. Was Dec Armed Fo 1 Armed Fo 1	edent Ever in orces? 2 \(\text{No} \) 5 ve ates: 10 /	/11/42 1	Vas Decede Yes, specif		anic Orig Mexican, Specify:	jin? (Specif , Puerto Ric	y Yes or No- an, etc.)		4. Race - Americ Black, White, Specify: Blace	etc.
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212	ed with ygiene. Jer ther	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) -		corney					La		
land	uld be fil lental H ked otl	To Be	17. Father's Name (First, Middle John Henry Es					18			irst, Middle, Va Fie		iumame)	
Maryland	12 shound hand hand hand hand hand hand hand ha		19a. Informant's Name/Relation	ship (Type, Print)					d Number	r or Rural R	oute Numbe	r, City or	Town, State, Zip	Code)
re,	s 1 and if Healti Item 2		Geneva Escoe 20a. Method of Disposition		20b	. Place of Dispo cemetery, cren			rcle	Silve	er Spr		Md. 20 ation - City or To	906 wn, State
Baltimore,	. Page tment o tant: if		1 ⊠ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Specify)	State	Gate Of	_		04	4/4/20	005	Sil	ver Spri	ing, Md.
Ba	permit Dapar Impor any in		21. Signature of Funeral Service	Liensee	10108	22	Name and				unera	1 Ho	nes, P.A	20747
			23a. Part1. Enjer the disease, o shock, or heart failure. Lis	r complications that of tonly one cause on e	aused the de	eath. Do not ente	er the mode	of dying,	such as c	cardiac or re	espiratory ar	rest,	ie, nu.,	Approximate Interval Between Onset and Death
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P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		irth 2 ☐ Fe ant at time o	etal death 3	Ectopic pred Other (spec					23	d. Date of delive Month	ry Day Year
	w requires that been signed t should be det	by	Part II. Other significant condition Lung Cancer	ons contributing to d	eath but not r	esulting in the ur	iderlying cau	use given i	in Part I.					e cause of death? ably 4 Dunknown
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Vita	rsicien: Th s cartificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hennital	npatient 2	ER/Outpatien	2 DOA	0.1			heck only or	7)	□Other (Specify	200
n of	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this cartificate his completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 □ Pendi	28a. Date		28b. Time of	280	c. Injury at Work?	t Nuis	28d	. Describe h)
visio	or Attend after death Director: / in by the f	Certification;	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	nined 286. Place	of Injury - At	home, farm, stre	M eet, factory, o		s 2 □ N	_	Location (S	treet and	Number or Rura	Route Number,
ā	pital or A urs after erel Dire		Tiomicide	Dulida	ng, etc. (Spe						City or Tow			
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Exeminer: On the band man	best of my k asis of exami ner stated.	nowledge, death nation and/or inv	occurred at estigation, in	the time, n my opini	date and ion, death	place, and occurred a	due to the d at the time, d	ause(s) ai late and p	nd manner as sta lace, and due to	ated. the cause(s)
	To t To t com	Σ	29b. Signature and title of certifie	er I- M				License n					signed (Month, L	
-	Z+1		30. Name and address of person	who completed caus	e of death (It	em 23a) (Type, F	Print)	D0003		201			1 29, 20	
	Sta Registr		31. Date filed (Month, Day, Year	S. Oser, 1				AV.	oce.	304,	PITAG	r 5p1	ing, MI	. 20902
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Month **Physician** Barbara Ann Fersner March 17, 12:50P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1704 Quarter Avenue Capitol Heights Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 5,1940 9. Birthplace (State or Foreign **Funeral** 1□M 2□X Days Hours 577-56-4230 64 Director Washington DC Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1. Yes 2 No Director Maryland Prince George Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 1704 Quarter Avenue United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Ital eny injury or other treumatic event, it a Mudical Exammen 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker Twelth 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Regina Smalls Robert Elum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1704 Quarter Avenue, Capitol Heights, Maryland 20743 19a. Informant's Name/Relationship (Type, Print) Sherell Fersner/Daughter Date 25, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March XXBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cedar Hill Cemetery 2005 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert G. Mason Funeral Home 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Jua to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-transit V D that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 🗌 Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. escribe how injury occurred Certification: Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 I or Attending Physician: efter death. Director: After this certifica

the Maryland

Baltimore, Maryland 21215-0036

To the Hospitel within 24 hours e

31. Date filed (Month, Day Year) APR 0 6 2005 State Registrar

29a. Certifier

4 🗌 Homicide

(Check only one)

29b. Signature and the of certified

32. Registrar's Sign

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

led cause of leath (Item 23a) (Type, Print) 30. Name and address

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day RAE CLEMENTS FENTON April 2005 04:10 A [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Sacred Heart Home Hyattsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Days Hours Director 578-05-2799 92 21, 1912 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28e-1 ahow any injury or other treumatic event, the Medical Examinating must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3201 Nicholson Street 20782 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Accountant WSSC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertie Hayes James Clements 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Fenton, Spouse 3201 Nicholson Street, Hyattsville, Maryland 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) 04/06/2005 Alexandria, Virginia Metropolitan Crematory 21. Signature of Juneral Sérvice 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sheek, or heart failure. List only energiause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events <u>Hypertension</u> Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed Atrial Fibrilation resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medicai Parkinson's Disease the ettending IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy jo Month Dav Year 5 Other (specify) P.O. 4☐Pregnant at time of death detached 9☐ Unknown 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dementia End Stage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√ No 24a. Was an page 2 certificate 1 Yes **2**₹ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: P 1 ☐ Yes 2√2 No 2 ER/Outpatient 3□ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 X Natural Injury 5 Pending after death.

i Director: Af
d in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide within 24 hours a To the Funerei [1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 51520 04-05-2005 30. Name and address of person who complete se of death (Item 23a) (Type, Print) Bahram Pishdad, 1328 Southern Avenue SE Suite #310, Washington, D.C. 31. Date filed (Month, Day, Year)

APR 0 5 2005 Registrar

			State Registrar	of Maryland / Depa	artment of He		Mental Hygie	6000	13269
	9:		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia	_	MARILYN L. FAUNCE				April 3,	2005 Yea	12:15 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or L	ocation of Death		4c. County of De	
300			8002 Fair Breeze Drive		Severn			Anne Art	
	Funeral Director		5. Social Security Number 6. Sex 1 → M 2/CXF	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Young) Dec. 14,	9. E 1944	Birthplace (State or Foreign Country) Ohio
	and w	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	daryla f sho	ō	Maryland Anne Arundel	Severn					1 ☐ Yes 2 X No
	the 28a-	Director	10e. Street and Number	Severn	10f. Zip Code		10g	. Citizen of What	Country?
	3s or		8002 Fair Breeze Drive		21	144		USA	
36	72 hours after death with the Maryland "neturel", or Items 23s or 28a-f show dical Examination and Lein Lilliau at	by Funeral	1 Never Married 2 Married 1 Yes	orces? 2√2 No iive	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒ No	panic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, W	mencan Indian, hite, etc. White
21215-0036	hour turel'		3√X Widowed 4 □ Divorced Year or 15. Decedent's Education		dent's Usual Occupat	ion	16	b. Kind of Busine	ss/Industry
75	L	Completed	(Specify only highest grade completed	(Give	kind of work done du DO NOT use retired)	iring most of worl	king	b. Kind of Dasino	Samuel Strategy
212	filed within Hygiene. other then "other then "ont, It e Mes	шо	Elementary/Secondary (0-12) College	(1-4or5+) Finge:	rprint Spe	cialist		FBI	
b		Вес	17. Father's Name (First, Middle, Last)	9			e (First, Middle, Ma.	iden Sumame)	
ylaı	2 should be and Mental is marked (eumatic ev	To	Martin Gilboy				Coristin		
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street an			-	
	s 1 and 2 should of Health and Men item 27 is marke other treumatic		John M. Faunce / Son 20a, Method of Disposition	20b. Place of Dispo	Fair Bree	ze Drive		Marylan (c. Location - City	
Baltimore,	Pages nent of P int: If ite		1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from	n State cemetery, crei	matory or other place,	04/0	07/2005 C1		
퍒			`4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee	Resurrect	tion Cem. 2. Name and Address				
Ba	permit. Departr Importe any inje		Aug Pikala	1 2	973 SOLOM	ONS ISLA	ND ROAD,	EDGEWATE	R, MD. 21037
п			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	cafused the death. Do not ente				,	Approximate Interval Between Onset and Death
	Physician	Y II	Immediate Cause (Final disease or condition resulting in death)	Oronary	artery	also	ease		4 yrs,
	/Medical Examiner		Due t	(or as a consequence of):	and.				many years
		er	Sequentially list conditions, bb.	mes.			100		
	uted d ansit	Examln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	areted ce	elery S	60008	is		many yearny
ó	cate be executed physician and the burial-transit			(or as a consequence of):	00011	`1			my your
8760,	ate be nysicia he bu	dlcal	d	4 Coseles	Co lect	ruj			7000
9	ing ph	40	IF FEMALE:						
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant 1 Live	gnant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
<u>α</u>	that i		Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause giver	n in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
rds	w requires been sign should be	ed by					1 🗆 Yes	20 No 3□	Probably 4 Unknown
Vital Records,	The law reate has bee page 2 sho	Completed					24a. Was an autopsy performe	d? prior t	autopsy findings available to completion of cause of ?
/ita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
of \	Physicien: this certific ral director.	မ	1 ☐ Yes 2 No Hospital: 1 [Inpatient 2 ER/Outpatie		4 🗆 Nuising H	ome 5 Residence		pecify)
on c		lon:	1 Natural 5 Pending (Mo	e of Injury 28b. Time on th, Day Year) Injury	Work?	at ? es 2 □ No	28d. Describe how	injury occurred	
Division	of or Attendiater death. Director: A in by the fu	licat	2 Accident investigation 3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, st		00 20.10	28f. Location (Street	et and Number or	Rural Route Number,
Δi	after Direct	Certification:	4 Homicide determined bui	ding, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S	State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atte completely filled in by the fune	edical C	29a. Certifier (Check only one) Certifying Physician: To t						
	Fo the within Fo the comple	Me	29b. Signature indititle of certifier		29c. License	number	29d	. Date signed (Mo	onth, Day, Year)
	- > - 0) 001.		D	4051	ĵ l	4.4-	2005
2	(10)		30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print) Crofton	Conter	Crotho	44 -	
	Sta		31. Date file Month, Day, Year) APR 0 5 2005	use of death (Item 23a) (Type, 20, 46 CFT) Registrar's Signature	est s			•	
	Registi	at	MIN DO COOS	THE PARTY					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3 Time of Death Month. **Physician** BOBB 4 AM FITZGERALD 10:45 Dr. 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CAMBRIDGE MACHESTER GENERAL DORCHESTER HOSPITAL 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Oay, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7 Age (In vrs last hirthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min Director 68 229-44-6731 Dec.19,1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 14 Yes 2 □ No Director Marvland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21613 Douglass Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dail Hygiene.
other than "natural", or Item Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: <u>م</u> 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Darling International Elementary/Secondary (0-12) College (1-4or 5+) Rendering Company MKnum Truck Driver permit. Pages 1 and 2 should be fited:
Department of Health and Mental Hygic
Important: If item 27 Is marked other:
any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Lonnie Fitzgerald Isabelle Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fitzgerald/Daughter 4302 Abeerdeen Dr., Mt. Laurel, N.J. 08054 Barbara 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation d □ Other (Specify) Bethel Cemetery 04-09-2005 Cambridge, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home
524 Race Street, Cambridge, Maryland 21613 21. Signature - Fur eral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular /Medical Due to (or as a consequence of): **Examiner** Atria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of deliver. 23b. Was decedent pregnant 3 Ectopic pregnancy 1 I ive hirth 2 Fetal death in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate 2 1 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street 80H Malking MD 31. Date filed (Month. APR 0 5 2005 Pristrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrer Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Yeer VIRGINIA MARY FRY /Medical APRIL 2005 9:13 A 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner BERLIN
If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. ATLANTIC GENERAL HOSPITAL WORCESTER 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💆 F Months Director 078-26-9138 73 JANUARY 9. 1932 NEW YORK Usual Residence of Decedent 10a State 10b. County Pages 1 and 2 should be filed within 72 incurs.
Then of Health and Mental Hygiene.
Trant: If Item 27 is marked other than "natural," or Itams 23e or 28a-f show riant: If Item 27 is marked other than "hatural," or Itams 23e or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND WORCESTER OCEAN PINES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 MATES COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: φ Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 JAMES DAVEY MARION SCHROEDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is n any injury or other traum once. JAMES A. FRY HUSBAND 4 MATES COURT OCEAN PINES, MARYLAND 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 ☐Dogetion 5 ☐ Other (Specify) CREAMATORY OF DELMARVA 4/04/05 DELMAR, DELAWARE permit. Departn 21. Signature de la Service Licen 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Bowel Perforation with complications resulting in death) /Medical Due to (or as a consequence of): Examiner Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXCENT Due to (or as a consequence of) attending physician a for use as the burial-Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 mopths? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has birector, page 2 s 24a Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

12 Yes 21 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann ol Death

P.O. Box 68760. Records.

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Division of Vital After after death. To the Hospital within 24 hours a To the Funeral I Hospital

State Registrar

31. Date filed (Month, Day, Year) APR 0 6 2005

Hndrea

29b. Signature and title of certifier

1 Matural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 Could not be

determined

733 Darer MO 32. Re

and manner stated.

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Healthman Dr Berlin, mo

28c. Injury at Work?

1 Certifying Physisian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D53612

1 🗌 Yes

2 🗆 No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

4/1/05

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

DHMH 17 Rev 1/2001

Franklir

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Yee **Physician** CHARLES FREYMAN THOMAS 6:40 P 31, MARCH 2005 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CARROLL SYKESVILLE 5060 BARTHOLOW RD. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 6. Sex 1**∑**M 2□F 75 Director 213-24-7663 1929 MARYLAND 20, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Director WESTMINSTER CARROLL MD. 10f. Zin Code 10g. Citizen of What Country? 10e Street and Number 21157 USA 413 BARNES AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status ifiled within 72 hours after de Hygiene. other than "natural", or Item Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ Year or Dates: WW II 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPPLY SERGEANT MILITARY 9 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumetic event, 2008. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM RUSSELL FREYMAN RUTH LOUISE LITTLE ပ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 BARNES AVE., WESTMINSTER, MD. 21157 BETTY E. FREYMAN WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State DEER PARK CEMETERY 4/4/05 SMALLWOOD, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Igna 14 Huneral & rvice Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as çardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit certificate be executed Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 12 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Ther (Specify HOUSE Hospital: 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident efter death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital
within 24 hours e
To the Funeral 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptile WIL an LYIVA who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Drive Ste C Westminster, 170 21/57 10 obert 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			For State Registrar	State of M	1aryland / I		rtmen tificat					iene () og. No.	05	13274
	Physici /Medic		1. Decedent's Name <i>(First, Middle, L</i> Martha	ast) FREEDMAN							2. Date of Deat Month April 1		Year	3. Time of Death 12:03 PM
	Examin		4a. Facility Name (If not institution, g Mariner Health o					Town, or hesda	Location o	of Death			nty of Death	ry
	Funeral Director		5. Social Security Number 6. 078-38-2016	Sex 7. A 1 □ M 27 F	nge (In yrs. last bii 95	rthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth Month, Day, June 5,	°£309	9. Birthe New	place (State or Foreign atry) York
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Lo	cation							10d. Inside City Limits
	e Mary	ctor	Maryland Montgo	mery		Beth	resda							1 ☐ Yes 2√ No
	h with th	al Director	10e. Street and Number 5721 Grosvenor I	ane #257			10f. Zip	Code	20	814	1	-	of What Coul ed Stat	-
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modic. Exercited to notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 2 Telegraphic Services If Yes, Give Year or Dates	s? } No	1	Was Deceo f Yes, spec l ☐ Yes	ify Cubar	spanic Ori n, Mexican Specify:	i, Puerto I	cify Yes or No- Rican, etc.)	E	Race - Americ Black, White, Icify: wh:	
Baltimore, Maryland 21215-0036	in 72 hou 1 "natura	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a	(Give	lent's Usua kind of wo	rk done d	luring mos	t of worki		16b. Kind of	f Business/In	dustry
212	ed with	Comp	Elementary/Secondary (0-12)	College (1-40	r 5+)	Cler	k						unting	3
land	uld be filk flental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, La: Joseph	Scheiber							(First, Middle, I		name)	
Mary	nd 2 shouth and No. 27 is main		19a. Informant's Name/Relationship Genie Israel, Da		191	b. Mailir 1801	g Address Roc	(Street a	nd Numbe Le Pi	er or Aura .ke #	404, Roc	City or Tov	wn, State, Zip e, MD	20852
nore,	ages 1 ar		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3						!	04/0	4/05		on - City or To	
Baltin	bermit. P Departme mportani any injury		* 4 □ Donation 5 □ Other (Spec 21. Signature of Fune 11 > Trick Lice	-	Long	Ta	rens4	d Arky's	s Hebr	ew F	uneral l	lome		LI, NY
			23a. Part1. Effect the disease, or co shock, or heart failure. List on Immediate Cause (Final	y one cause on each	line.	not ent					, Washir or respiratory arr		<u>рс</u> 2	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or a	ac Arres	of):								
		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	sclerot:		leart	Dise	ease					
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		tension	of).								
8760,	cate be executed obysician and the burial-transit	dical E		d. Blinds								· · · · · · · · · · · · · · · · · · ·		
.O. Box 6	ath certific titending p or use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown		2 Fetal death at time of death		Ectopic pi Other (sp						Date of deliving Month	ery Day Year
ecords, P.	w requires that the de been signed by the a should be detached t	þ	Part II. Other significant conditions Neuropathy	contributing to death	but not resulting	in the u	nderlying c	ause give	en in Part I			oaccouse c		he cause of death?
α		Completed					·				24a. Was a autops perform	y	b. Were auto prior to co death? 1 Yes	ppsy findings available impletion of cause of
of Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	utient 2□ER/O		nt 3 DC	Othe			n <i>(Check only or</i> me 5 ☐ Resid		Othor (Specie	6.1
on of	ding Phy h. After this funeral d	\vdash	27. Manner of Death 1 🛣 Natural 5 🗆 Pending 2 🗀 Accident investigat	28a. Date of Ir (Month, L		Time of Injury		28c. Injury Work	at	4	28d. Describe h			y)
Division	i or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not determine	be 28e. Place of	Injury - At home, f etc. <i>(Specify)</i>	farm, str	eet, factor	y, office			28f. Location (S City or Tow		ımber or Run	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. **Extra The Teneral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 ACertifying (Check only one) 2 Wedical Ex	Physician: To the be aminer: On the basis and manner	of examination a	ge, death	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, a	and due to the c ed at the time, d	ause(s) and ate and plac	manner as s ce, and due t	stated. o the cause(s)
	To the within 2.	Me	29b. Signature and title a certifier		/		29	c. License		1			gned (Month,	
•	5		30. Name and address of person wh	o consulated cause o	f death (Item 222)) (Tune	Print\	ע	5369	Τ		prii	1, 200	در
			Ajay Reddy, M.	D., 6320 1	Democrac	у В1	.vd.,		nesda	, MD	20817			
:	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. Popi	strar's Signature	A	marke	P						

			State of Maryland / Depart		=	_	10075
		•	1 - State Registrar Certif	ficate of Death	Reg.	2000	132/3
	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Lori Michelle Guthrie 4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death	April	2 2005 4c. County of Death	3:40A ^M
	Examin	er	143 Mount Rocky Lane	Colora		Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
	Director		211-64-9441 33 Yrs.	o d	ct. 27, 1		sylvania
land	Mo ≒		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	tion			10d. Inside City Limits
Man	a-f sh	ctor	Maryland Cecil Colora				1 ☐ Yes 🛣 No
death with the Maryland	or 28	Directo		10f. Zip Code		. Citizen of What Cou	
v chee	18 23e	eral	143 Mount Rocky Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21917		14. Race - Ameri	
ĕ	r Item piner	Funeral	1 Never Married 2√F Married 1 TYes 2 12 No	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	etc.
1215-0036 within 72 hours after	IFXIII	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates:	Yes 21 No Specify:		Specify: Whit	
15-(5)	"netr adica	Completed	15. Decedent's Education 16a. Deceden (Specify only highest grade completed) (Give king DO	nt's Usual Occupation ad of work done during most of worki NOT use retired)	ng 161	b. Kind of Business/Ir	ndustry
212 with	r then	omp	Elementary/Secondary (0-12) College (1-4or 5+) 3 Homen			Own Home	
ם פולים	al Hyg	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai		
yla yla	and Menial Hygiene. is marked other then "neturel", or Items 23e or 28a-f show aumetic event, the Medical Examinar must be multiful at	To	Paul F. Miller		lene Kaul		
Maryland 21215-0036	th and 7 is rr traum			Address (Street and Number or Rura			o Code)
ē.	f Heali item 2 other		20h Place of Disposition	ion (Name of	-	c. Location - City or T	own, State
E S	nent o		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	ingham April	6,2005	Colora, M	D
Baltimore,	Department of Health and Menta Important: If item 27 is marked any injury or other traumetic so			lame and Address of Facility R.T. South Queen St.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac of	r respiratory arrest		Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)	gent Carci	noma	2	Onset and Death
	/Medical xaminer		Due to (or as a consequence of):	/			
		je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
Cuted	nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Classes Cause (Industrying Cause) (Industrying				
760,	sician and burial-transit	calEx	resulting in death) Last Due to (or as a consequence of):				
	, × 9	_	d.				
Box	ending use a	M/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec	ctopic pregnancy		23d. Date of deliv	•
Records, P.O. Box 68	the att	by Physician/Med		Other (specify)		Month	Day Year
P.O.	led by the a	, Ph	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	should be det				1 🗆 Yes	2 ☑ No 3 ☐ Pro	bably 4 □Unknown
000	is bee 2 shoi	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
	ate has	Som			performer 1 Tes 2	d? death?	2 No
Vital	sertific ector.	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
vision of Vita	st death. •ector: After this certificate haby the funeral director, page	. To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	me 5 DRésidence 28d. Describe how	e 6 Other (Speci injury occurred	fy)
ion and	death. ctor: Afte y the fune	atlor	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	after des I Directo d in by th	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
Div	within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1	occurred at the time, date and place, stigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
, d	withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month	Day, Year)
			Clan Summer MD	1005644	9	114105)
(5		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	+ High St. S	uite 3	DO Elk	ton MD2145
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
			THE TO LOUD WAR TO THE TOTAL TO THE TOTAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day M3/Ch Month 30, 2005 **Physician** 8:45P M Richard Noel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Westminste Norrs CALLOIL enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month), Day, Year) JUNE 25, 1917 Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 213-01-9159 1₩ M 2□ F Months MARYLAND 87 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show Examiner must be notified at Yes 2 No MARYLAND CARROLL WESTMINSTER Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 87 BOND STREET 21157 UNITED STATES or Items 23a death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 14 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: WHITE þ 3 Widowed 4 Divorced WWIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PROJECT ENGINEER STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DENTON GEHR ANNA ABBALINE WHITMORE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE L. GEHR/WIFE 87 BOND STREET, WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State WESTMINSTER CEMETERY 4/2/2005 WESTMINSTER, MARYLAND ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME withou 91 WILLTS STREET, WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death (23a. Part). Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ediate Cause (Final Myocardial **Physician** one how disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 8 hours Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter the design Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown I signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen : 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 🗹 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident

Box 68760 Division of Vital Records, P.O. or Attending Physician: Director: filled in by within 24 hours a

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifies 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 100059943 29d. Date signed (Month. Dav. Year) 30, 2005 March

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Arbel MO Stener Are 295

31. Date filed (Month, Day, Year)

32. Registras Signature

APR 0 1 2005 >

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Medical

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0 D

State

Registrar

			1 _ State	f Maryland /		irtment of He <i>tificate of D</i>			- U U U	13277
			Registrar 1. Decedent's Name (First, Middle, Last)		OGI	uncate of D	calli	2. Date of Death	g. No.	3. Time of Death
	Physici /Medic		MARY HAZEL	GOETZ				April	6, 2005	5:45 P ^M
	Examin		4a. Facility Name (If not institution, give street and nur	nber)		4b. City, Town, or L			4c. County of Death	
			1520 Dual Highway 5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthdav)	Hagers1		8. Date of Birth	Washin	-
	Funeral Director		214-09-2809 1 M 2 MF	86	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) March 3	, 1919 We	nplace (State or Foreign untry) st Virginia
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Manyli 1 sho	tor	Maryland Washington	Hag	erst	own				1X1Yes 2☐No
	th the or 28a and the	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ath wi	ral	1520 Dual Highway		1	21740			U.S.A.	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show he Medical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Dece Armed Fo 1 Never Married 2 Married 1 Yes	edent Ever in U.S. rces? 2 1 1 140	i	Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amei Black, White	
Maryland 21215-0036	ral', o	by	3 XWidowed 4 □ Divorced If Yes, Giv Year or D	/8	1	I∐Yes 20XINo	Specify:		Specify: Wh	ite
5-0	natu	Completed	15. Decedent's Education (Specify only highest grade completed)	168	(Give	lent's Usual Occupati kind of work done du OO NOT use retired)	on ring most of workir	ng 11	6b. Kind of Business/I	ndustry
7	l withir iene. r than	omo	Elementary/Secondary (0-12) College (1	-4or 5+)		Riveter			Aircraft M	fg.
פ	al Hyg I otha vant,	Be C	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle, Ma	aiden Sumame)	
ylaı	ould b Ments narked	To	Clarence Blaine	Snyd			Eva	Laura	Marti	
Mar	d 2 sh th and th and traum		19a. Informant's Name/Relationship (Type, Print) Arvella L. Snyder Si						City or Town, State, Z aryland 21	
ē,	s 1 an f Heal item 2 othar		20a. Method of Disposition	20b. Place		sition (Name of natory or other place)			Oc. Location - City or	
<u>m</u>	Page: nent o ant: If ury or		1 № Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)			L1 Cemeter		09-05	Hagerstown	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-1 show any injury or othar traumatic avant, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses R. RULL BRAM		22	Name and Address	Çoffman I	uneral	Home, Inc.	
			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e	aused the death. Do	not ente	or the mode of dying,	such as cardiac of	r respiratory arres	gerstown,	Maryland 217 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CI/O		ian				Onset and Death
	/Medical Examiner		resulting in death)	(or as a consequence						
		ē	Sequentially list conditions, if any, leading to immediate Due to	or as a consequence	e of):					
	cuted id	Examiner	Cause (Disease or injury that initiated events							
90,	oe exec cian ar ourial-ti	I Ex	resulting in death) Last Due to	or as a consequence	e of):					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical	d			0.0	V1 ()			
Box (h certii ending use a			come of pregnancy irth 2 Petal deat	nh a l	Ectopic pregnancy			23d. Date of deli	
O. B	res that the death certifi igned by the attending be detached for use a	Physician/M		ant at time of death		Other (specify)			Month	Day Year
۵.	that the	Phy	Part II. Other significant conditions contributing to d	eath but not resulting	in the ur	nderlying cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds,	quires n sign uld be	ed by	Aplastic	Anemia	α_{A}	Por 10	years	1 ☐ Yes	2 00 3 □ Pro	bably 4 Unknown
900	law requir as been si 2 should l	Completed	///		(/		J	24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
<u>~</u>	sician: The taw s certificate has t irector, page 2 s	Com						perform	ed? death?	2 No
Vita	sician certific rector.	Be	25. Was case referred to medical examiner?			Othor	26. Place of Death			
ō	y Phys er this eral dii	n: To	27. Manper of D ath 28a. Date		. Time of	28c. Injury a	at 2	ne 5 esiden 28d. Discribe hov	ce 6 □Other (Spec v injury occurred	sify)
io	Attending F death. ctor: After y the funer	atio	2 Accident investigation	th, Day Year)	Injury	Work? M 1 □ Ye	es 2 □No			
Division of Vital Records,	l or Attendation after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place build	of Injury - At home, ing, etc. (Specify)	farm, str	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	e Hospital 24 hours a e Funeral I letely filled		29a. Certifier Certifying Physician: To the	best of my knowled	ge, death	n occurred at the time	, date and place, a	and due to the cau	use(s) and manner as	stated.
	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		asis of examination a ner stated.	and/or inv	1				
	To To	-	29b. Signature and title of certifier		/ "	29c. License	D1.//	72	d. Date signed (Month	O 10-1
,			30. Name and address of person who completed cause	se of death (Item 23a	(Ou) (Type.	Print)	N494	()	apul	0, 2005
_			Hind Hamda	n, MI) •	1130	OPAL	CT.	Hagers	town, mi)
	Sta Registr		31. Date filed (Month, Day, Year) 32. F	legistrar's Signature	1	heels		/		
	negisti	धा	MI IL 0 0 2000	COMECUA IV.	100	10-10 page				

			_ For	State of Ma		d / Depa	artment of	Health and	Mental Hygi	•	e. : 194	270
			1 - State Registrar	•		Cei	rtificate o	f Death		, No. UU) 0 6	270
	Physici /Medic		Decedent's Name (First, Middle, L VONDA DAWN	GRIMM					2. Date of Death Month April		9ar 2005 6:0	e of Death
	Examin		4a. Facility Name (If not institution, g					, or Location of De	ath	4c. County of		
			WASHINGTON COUNT 5. Social Security Number 6.		e (In vrs	last birthday)	HA If Under 1 Yea	GERSTOWN ar If Under 24 H	rs. 8 Date of Birth		HINGTON Birthplace (State	te or Foreign
	Funeral Director		214-36-0241 Usual Residence of Decedent	1□M 2DTE	65	Yrs.	Months Day			1939	Birthplace (State Country) MARYLAN	D
	death with the Maryland ms 23a or 28a-f show croust be notified at	tor	10a, State 10b, County MARYLAND WASHI	NGTON	10c. Cit	y, Town or Lo		DYSVILLE				e City Limits Yes 2⊠No
	r 28a	Directo	10e. Street and Number	1102011			10f. Zip Code		10	g. Citizen of Wha	at Country?	
	th with	ai D	18728 MANSFIELD	ROAD				21756		U.	S.A.	
136	hours after death with the Maryla lurat', or Itams 23a or 28a-f shou at Enarcher must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 Ⅸ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Decedent o If Yes, specify Co 1 ☐ Yes 2 🎇 N		(Specify Yes or No- erto Rican, etc.)		American Indian White, etc. WHITE	
15-0036	원 표 표	Completed	15. Decedent's (Specify only highest (Education grade completed)		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of w	vorking	Sb. Kind of Busin	ness/Industry	
7.	within 72 iene. than "nai	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	ine.	COOK	•		NURSIN	G HOME	
and	al Hygi I other	Be C	17. Father's Name (First, Middle, La.	st)		-			ame (First, Middle, Ma	aiden Sumame)		
ya	ould b Menta arked aric e	To E	JOHN A. DRAPER			_			E MELLOTT			
Ma	12 sh h and 7 is m traum		19a. Informant's Name/Relationship						Aural Route Number, OAD, KEEDYS			D 2175
<u>6</u>	1 and Healt tam 2		J. ROBERT GRIMM J	IR. / SUN	20b. F	_	osition (Name of matory or other p				ty or Town, State	
ē	Pages ent of nt: If ii ry or o		1 XBurial 2 □ Cremation 3 14 □ Dopartion 5 □ Other (Spec				CEMETE		08/2005 K	EEDYSVT	LLE, MAI	RYLAND
Baltimore	permit. Departm Importa any inju		21. Signature of Hungral Service Lic	Paul M		22	2. Name and Add		7606 Old Boonsboro	Nationa	1 Pike	713
	Physician		23a. Pall 1. Enter the disease, 3 shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused by one cause on each ling	the deat	h. Do not ent	ter the mode of d	ying, such as card			Approxir	
68/60,	Medical Examiner bhysician and the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as b. Due to (or as c. Due to (or as d.	a conseq	1ti	o cca ple	l faec Mye	ulis se I com	2129	5 d	ears
O. Box 6	The law requires that the death certificate tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ⊇ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregnar Other (specify)			23d. Date of Month	•	Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	nderlying cause	given in Part I.	23e. Did toba		ute to the cause	of death? Unknown
Hecords,		Completed							24a. Was an autopsy perform 1 \(\text{Types} \) Yes 2	prio ed? dea	re autopsy finding to completion outh?	gs available of cause of
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Hamitals t					eath (Check only one			
ō	hys his	tion; To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigat	Hospital: Inpatie 28a. Date of Inju (Month, Da	ıry	ER/Outpatier 28b. Time o Injury	f 28c. In		Home 5 Resident		(Specify)	
DIVISION	of or Attanding Patter death. Director: After the in by the funera	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 290 Place of Ini			reet, factory, office	ce	28f. Location (Stre City or Town,	et and Number State)	or Rural Route N	lumber,
_	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	if examina	owledge, deat ition and/or in	h occurred at the	time, date and play y opinion, death oc	ice, and due to the cas courred at the time, dat	sse(s) and mann e and place, and	er as stated. d due to the caus	e(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifies	\	1		29c. Lice	ense number	29	d. Date signed (i	Month, Day, Yea	r)
			Htudt	Jour	do	I, me	0	D46L	M3 F	teril	6,21	005
51	1-3		30. Name and address of person wh	o completed cause of o	death (Iter	п 23a) (Туре,	Print)	000	71- CT	· Ha	donnton	WW
11	Sta		31. Date filed (Month (13) (Yeft) 17	2005 32. Rogistr	ar's Signa	ature	110) //3	IMS	2174
	Regist	ar		1400		10. 6	per					

			4	artment of Health and Mental Hyg	piene 0 0 5 1 3 2 7 9			
			Decedent's Name (First, Middle, Last)	2. Date of Dea Month				
	Physici /Medic		Helen Irene Hindle	April	5, 2005 1:55 A M			
1	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
			Abbey Manor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	LaPlata If Under 1 Year If Under 24 Hrs. 8, Date of Birth	Charles 9. Birthplace (State or Foreign			
н	Funeral Director		577-01-2234 1□M 2□ 86 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Min. May 5				
	D.		Usual Residence of Decedent		·			
	shov	o.	10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits 1 ☐ Yes 2 17/No			
	28a-f	Funeral Director	10e. Street and Number		I Og. Citizen of What Country?			
	3a or	IDI	5185 Colebrook Drive	20646				
	death	nera		Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,			
98	or Ite	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 Yes 2 Xo Specify:				
21215-0036	72 hours after death with the Maryland neturel', or Hems 23a or 28a-1 show lical Eval. in er must be notified at	ed by	3 Wildowed 4 Divorced Year or Dates:		WIIICE			
15	in 72 n "nel	plete	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry			
212	e filed within al Hygiene other then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Payroll Specialist	County Govt.			
pu	0 = 0 \$	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Sumame)			
yla	should be and Mental amarked o	To Be	Luther C. Hicks	Clarrissa M.				
Maryland	nd 2 shalth and 27 is rr			ng Address (Street and Number or Rural Route Number Colebrook Drive,La P				
	le al		20a Method of Disposition 20b. Place of Dispo	esition (Name of Date	20c. Location - City or Town, State			
OE.	Pages ent of nt: ff it		Manual 2 Cremation 3 Hemoval from State	y Memorial 4/9/05	Waldorf, Maryland			
Baltimore,	permit. Pages ' Department of h Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licensee M00945 2	AREHART - ECHOLS FUNER	AT HOME D.A			
<u> </u>	90 E # 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	P.O. BOX 567. LA PLA	TA MD 20646			
			shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory arr	est, App ximate Interval Between Onset and Death			
	Physician /	ler	Immediate Cause (Final disease or condition resulting in death)	mende	Shot and South			
	/Medical Examiner		Due to (or as a consequence of):	11				
	X		Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury the party of the conditions).	- marghering				
	cuted	Examiner	Cause (Disease or injury that intitated events c.					
Ő,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):	0				
œ	icate b physic s the b	dical	d.					
9 x	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery			
Вох	death a atter d for u	lciar	230. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ in the past 12 months? 4 □ Pregnant at time of death 5 □	Ectopic pregnancy Other (specify)	Month Day Year			
P.0	at the by the tacher	hys	9 ☐ Unknown					
	law requires that the de as been signed by the 2 should be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the u		bacco use contribute to the cause of death?			
orc	requi	eted	Cid Si A Mass Sug		es 2 No 3 Probably 4 Unknown			
Vital Records,	has has	Completed	alling Ilista Herrit 1 Je	24a. Was a autops perform	sy prior to completion of cause of			
a		e Co	25. Was case referred to medical	1 □ Yes	No 1 Yes 2 No			
<u>S</u>	yeicien: is certific director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (Check only on at 3 DOA Other: 4 Nursing Home 5 Reside	/			
n of	Attending Physicien: r death. sctor: After this certific by the funeral director,		27. Manney of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		ow injury occurred			
Siol	tendir eath. or: Al	catic	2 Accident investigation	M 1 Yes 2 No				
Division	or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	eet, factory, office 28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)			
	Hospitel		29a. Certifier 1 € Certifying Physician: To the best of my knowledge, deat	occurred at the time, date and place, and due to the co	ause(s) and manner as stated			
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, d	ate and place, and due to the cause(s)			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		9d. Date signed (Month, Day, Year)			
			1 Ind Ind	12001009	4-5-05			
(Ω }		30. Name and address of person who completed cause of death (Item 23a) (Type, Henry Burke, M.D. P.O. Box 25.)					
0	i) b Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	39,La Plata,MD 20646				
	Registr		APR 0 6 2005	perk)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Clifton Wilson Hall 12:20A M April 4, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **West Virginia** 8. Date of Birth (Month, Day, Year)
Sept 13,1926 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1**∑**M 2□F 78 Yrs. Director 233-44-5352 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show the Medical Examiner must be notified at Yes 2 No **Funeral Director** Maryland Cecil **Elkton** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 United States 236 100 Coventry Court filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status XYes 2 No WW2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: White Be Completed by Year or Dates: Korea 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 Boilermaker Boilers Ith and Mental Hygie

27 is marked other if traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Augusta Hall Edna Reddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vartment of Health a cortant: If itam 27 is injury or othar trat Mary Hall/wife 100 Coventry Court, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4 Donation 2 2 21. Signatur Friedal Service Licensee Bethel Cemetery Apr 7, 2005 CHesapeake City, MD permit.
Departr
Imports
any inju 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 318 George St., Chesapeake City, MD 21915 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a construction of) P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☑No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 no 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) within 2 29b. Signature and 0 andress of person who completed cause of death (Item 23a) (Type, Print) 30. Name at 4+IVA ELKEON 57 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State 5 2005 Registrar

O5-2525 B.K.S HYOZH HAN

/Media	ian				2. Date of Dea APRIL	11, 2005 ^{ar}	3. Time of Death		
Examir		4a. Facility Name (If not institution, g	give street and number)	R	4b. City, Town, of SALISBU	r Location of Death		4c. County of Deat	th
Funeral Director		5. Social Security Number 6 217–69–3863	. Sex 7. Age (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	6-29-1961Birt	hplace (State or Forei
show		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or L	ocation	-0/-1	9/1901	- A	10d. Inside City Limi
28a-f sh	ctor	Maryland Wicomio	co	Salisbu	ry				1 🔀 Yes 2 🗆 1
23a or 28	Funeral Director	10e. Street and Number 504 Emory Court,	Apt. 103		10f. Zip Code 21804			Og. Citizen of What Co Korea	ountry?
"netural", or items 23s or 28s-f show dical Examiner must be mailified at	þ	11. Marital Status 1 □ Never Married 2(X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Spann, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
* 22	Completed	15. Decedent's (Specify only highest s	Education grade completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of work 1)	ing	16b. Kind of Business/	Industry
Hygiene. ther than " int, ine wa	S	12 17. Father's Name (First, Middle, La	et)	Chic	ken Farme		/Fire & Adiadala	Poultry	
and Mental Hygiene. is marked other than sumatic event, Ire M.	To Be	Wonsuk Han	<u>.,</u>			18. Mother's Name Soonim	Jun	vialuen эитате)	
and M is mar aumat		19a. Informant's Name/Relationship	* ** *					, City or Town, State, 2	
Health		Miok Nam Han/wif		20b. Place of Dispo	The second secon			Salisbury,	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event, Item and injury or other traumatic event, Item and injury.		1 ☐ Burial 2 【XCremation 3	☐Removal from State	cemetery, cre	y Cremato	e)	4	20c. Location - City or Salisbury,	,
Depart Import any in		Signature of Fun ral Service Lic	ensee CFSf		2. Name and Addre Holloway 501 Snow	Funeral H	ome Pro: Salish	fessional A ury, MD 218	Associatio
nysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the ly one cause on each line. a. Atherosc	e death. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
Medical xaminer	35		b						
nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
physician and s the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a c	onsequence of):					
വര	/Med	IF FEMALE:	23c. If yes, outcome of	Drognancy					
വെയ	무	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 € 4 Pregnant at tir	_Fetal death 3 L	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
വെയ	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		_ ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
വെയ	۵	1 ☐ Yes 2 ☐ No		not resulting in the u		en in Part I.		pacco use contribute to	
been signed by the attending should be detached for use a	Completed by Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		not resulting in the u		en in Part I.	1 Ye	n 24b. Were au	obably 4 Ninknov
been signed by the attending should be detached for use a	Be Completed	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner?	contributing to death but r		underlying cause give	26. Place of Death	24a. Was a autops perform	n 24b. Were au prior to c death? 2 No 1 Yes	obably 4 Ankno topsy findings availa completion of cause 6
been signed by the attending should be detached for use a	To Be Completed	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions 25. Was case referred to medical	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier	anderlying cause given	26. Place of Death	24a. Was a autops perform Yes 2 (Check only onne 5 Reside	n 24b. Were aul prior to c death?	obably 4 Ninkno topsy findings availa completion of cause of
tter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached tor use a:	To Be Completed	1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	ER/Outpatier 28b. Time o Injury	anderlying cause given	26. Place of Death ar: 4 □ Nursing Hor at 27 Yes 2 □ No	24a. Was a autops perform Yes 2 (Check only on me 5 Reside 28d. Describe ho	as 2 No 3 Pro 24b. Were autrice to compare	topsy findings availation of cause of 2 No
tter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached tor use a:	Certification; To Be Completed	1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case reterred to medical examiner? 1 Xes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 2 Accident investigate 3 Suicide 6 Could not determine	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28b. Place of Injury	28b. Time of Injury 28b. Time of Injury At home, farm, str. Specify) ny knowledge, deat amination and/or in	nt 3 DOA Othor 1 28c. Injun Worl M 1 reet, factory, office	26. Place of Death 3r: 4 Nursing Hor 4 2 Yes 2 No	24a. Was a autops perform Yes 2 (Check only on me 5 Reside 28d. Describe house 128f. Location (St. City or Town	n 24b. Were autroprior to chapter (Special Months) 24b. Were autroprior to chapter (Special Months) and 24b. Were autroprior to chapter (Special Months) and 24b. Were autroprior to chapter (Special Months) and 3 Proprior to chapter (Special Months)	topsy findings availat completion of cause of 2 No No No No No No No No No No No No No
വെയ	To Be Completed	1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Xes 2 No 27. Manner of Death 1 Natural 5 Pending investigation investigation investigation determine 2 Accident 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying Follows only 2 Medicel Eximals	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y building, etc. (Physician: To the best of reminer: On the basis of ex	28b. Time of Injury 28b. Time of Injury At home, farm, str. Specify) ny knowledge, deat amination and/or in	nt 3 DOA Othor 1 28c. Injun Worl M 1 reet, factory, office	26. Place of Death ar: 4 Nursing Hor r at r? fes 2 No	24a. Was a autops perform Yes 2 (Check only on me 5 Reside 28d. Describe house 28d. Describe house 28d. Location (St. City or Town and due to the care at the time, do	n 24b. Were aut prior to c dayth? 24b. Were aut prior to c dayth? 2 No 14 Yes 8) Ince 6 Other (Spectow injury occurred reet and Number or Ruit, State) Incuse(s) and manner as atte and place, and due 2d. Date signed (Month)	topsy findings availation pletion of cause of 2 No 2 No ral Route Number, stated. to the cause(s)
tter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached tor use a:	Certification; To Be Completed	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y building, etc. (Physician: To the best of reminer: On the basis of ex	ER/Outpatier 28b. Time of Injury At home, farm, stresspecify) ny knowledge, deat amination and/or indicate.	nt 3 DOA Other World M 1 Total reet, factory, office the occurred at the time the stigation, in my open occurred at the time total reet.	26. Place of Death ar: 4 Nursing Hor r at r? fes 2 No	24a. Was a autops perform Yes 2 (Check only on me 5 Reside 28d. Describe house 28d. Describe house 28d. Location (St. City or Town and due to the care at the time, do	n 24b. Were aut prior to c dayth? 24b. Were aut prior to c dayth? 2 No 14 Yes 8) Ince 6 Other (Spectow injury occurred reet and Number or Ruit, State) Incuse(s) and manner as atte and place, and due 2d. Date signed (Month)	topsy findings availation of cause of the ca

			1- State Unpend Item 23a;	ate of Ma	gyland / De C	partment of F per me G84 ertificate of a	lealth and N 224-28-05 Death	lental Hygie	ene 0 0 5	13282	
	Physici		1. Decedent's Name (First, Middle, Last) Randy Lee Hale					2. Date of Death April 17		3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, o	r Location of Death				
- II			Sacred Heart Hospita			Cumber1			Allegany		
2	Funeral Director		5. Social Security Number 6. Sex 1214-84-8323		(In yrs. last birthda 43 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Feb 24,		thplace (State or Foreign ountry) ryland	
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits		
	Mary a-f sho	tor	Maryland Garrett			G	rantsvill	e		1 ☐ Yes 2 ☑ No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene, tiem 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event, the Medical Examinat must be notified at	by Funeral Director	10e. Street and Number 300 Red Hill Road			10f. Zip Code	21536	10g	. Citizen of What Co USA	ountry?	
	death	nera	11. Marital Status 12. W	/as Decedent E	ver in U.S. 1	3. Was Decedent of H	lispanic Origin? (Spendan Maxican Puerto	ecify Yes or No-	14. Race - Ame Black, Whit		
21215-0036	ours after ei', or ite Examins	by Fu	1 Never Married 2 Married 1	☐ Yes 21 N Yes, Give ear or Dates:	0	1 ☐ Yes 2 ☒ No	Specify:	Filoati, Oto.)	Specify:	white	
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade con	n npleted)	16a. De	cedent's Usual Occup ve kind of work done b. OO NOT use retired	ation during most of work	ing 16	b. Kind of Business	/Industry	
121	within ene. than	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5-	+)	a. <i>00 NOT</i> use <i>retired</i> quipment O			Minerals	5	
d 2	Hygid Hygid other	Be Co	17. Father's Name (First, Middle, Last)			1		e (First, Middle, Ma	iden Sumame)		
/lan	wuld be Menta Menta arked stic ev	ToB	Marvin Hale, Sr.				Betty	Wilhelm			
Maryland	2 sho		19a. Informant's Name/Relationship (Type, F Tneresa Fischer, f			ailing Address (Street Red Hill					
	Heelth tem 27 other to		20a. Method of Disposition	rancee	20b. Place of Dis	position (Name of			c. Location - City or		
imo	Page nent o ant; if ury or		1 ☑ Burial 2 ☐ Cremation 3 ☑ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State		rematory or other places seph Cemet		3/2005 I	Hanover, 1	PA	
Theresa Fischer, fiancee 300 Red Hill Road, Grantsville, 20a. Method of Disposition 1 © Burial 2 Cremation 3 © Removal from State 4 Donation 5 Other (Specify) 21. Signature of Furbral Service Licensee M00723 22. Name and Address of Facility 21. Signature of Furbral Service Licensee 934 South Main St, Hampstea											
			23a. Part1. Enter the disease, or complicatio shock, or heart failure. List only one ca	ns that caused use on each lin	the death. Do not e.	enter the mode of dyin	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			roscleroti	ic Cardio	vascular	Disease	Oriset and Death	
1	Examiner			Due to (or as a	consequence of):						
	nsit .	Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):					
o,	ficate be executed physician and s the burial-transit	Ехаг	that initiated events c. The sulting in death) Last Due to (or as a consequence of):								
68760,	cate be	d									
	leath certifii attending p	/Me		yes, outcome of					23d. Date of de	livery	
D. Box	The law requires that the death certificate be executed site has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	□Live birth :: □Pregnant at t □Unknown		3 □Ectopic pregnancy 5 □ Other (specify) _	<u> </u>		Month	Day Year	
P.0	that the		Part II. Dthar significant conditions contribu	ting to death bu	t not resulting in the	underlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
Records,	w requires been sign should be	ed by	Pulmonary fibrosis:	Emphyse	ma			1 ☐ Yes	2 XNo 3□P	robably 4 Unknown	
eco	law re las bee	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
								performe 1 Yes 2		2 □ No	
of Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No Hospi	al: 1 ☐ Inpatier	nt 2 ER/Outpar	ient 3 DOA Oth		h (Check only one)	ce 6 □Other (Spe	soife)	
on of	≥ .ºº Þ	-	27. Manner of Death 1 Natural 5 Pending	a. Date of Injun (Month, Day	y 28b. Time	of 28c. Injur	y at	28d. Describe how		uny)	
Division	or Attendifier death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route City or Town, State)		ural Route Number,	
	To the Hospital within 24 hours a To the Funerei I completely filled	Medical Ce	29a. Certifier 1 ☐ Certifying Physicial (Check only (On the basis of	examination and/or						
	othe orthe omple	Mec	29b. Signature and tylle of Cartifier	and manner stat	iou.	29c. Licens	e number	29d	I. Date signed (Mon	th, Day, Year)	
			> Stiller	IN		OCM	E	Ap	oril 8, 20	005	
	MZV		30. Name and address of person who complete the complete that the complete the complete that the complete the complete that the complete t	ted cause of de	eath (Item 23a) (Typ	ne, Print) 111 Pe	nn Street	Baltimor	e, Maryla	and 21201	
	Sta Registi		31. Date filed (Month, Day, Year)		r's Signature	brock)					
	negisti	GH .	APR 1 2 20	III - 177	Buch The	Roselle 2					

			1 - State Amend Item	State of Mai	ryland / Dep 6842,042]	artment of H 9/05dhb rufficate of I	lealth and N Death	Mental Hy	gienę () () 5 Reg. No.	13283			
Н	Physici	an	1. Decedent's Name (First, Middle, Last)	Alacha	Audro	т по11		2. Date of De	Day Year				
j.	/Medic	cal	11 31 1 347 664	10000	Audre Audre			Dor.	4c. County of De				
Examine		er	4a. Facility Name (If not institution, give JOHN HOPKINS	BAYVIEW	γ	4b. City, Town, or Location of Death BALTIMORE			BALTIMORE				
Funeral Director			5. Social Security Number 6. Security Number 221–16–2108	7. Age	(In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 7-10-1	19 Year) 9. B	irthplace (State or Foreigr Country) ELAWARE			
Maryland 21215-0036	Maryland I-f show	Direct	10a. State 10b. County MARYLAND HARFORD		10c. City, Town or Le			~		10d. Inside City Limits 1 Xi Yes 2 □ No			
	th the		10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?			
	ath wi		155 EAST DEEN AVE	·····		210			US				
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28s-f show the Musical Exerciter must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2∑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	3- 14. Race - An Black, Wh Specify:	nerica <i>n</i> Indian, lite, etc. WHITE			
, D	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of Busines	s/Industry			
2	be filed within 72 ho Ital Hygiene. Ind other then "natul event, Ita Mudical	idm	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired PHONE OPE			TELEPHONE	COMPANY			
N	filed Hygi ther int.		17. Father's Name (First, Middle, Last)		TELLE	I HONE OIL		e (First, Middle,	, Maiden Sumame)	COLLINI			
a	should be nd Mental marked o	To Be	CORNELIUS WEST				LILLY	PHILLIE	?S				
ary	and and sum	-	19a. Informant's Name/Relationship (Ty	pe, Print)		3			er, City or Town, State	Zip Code)			
	1 and 2 Health Iem 27 I		PATRICIA GORDY/	DAUGHTER				ERDEEN,	MD. 21001	y Town State			
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	lemoval from State	1	matory or other plac	e)		20c. Location - City of MILLSBORO				
			*4 □Donation 5 □ Other (Specify) 21. Signature of Fund 13 - Nich s		MILLSBORO					DELAWARE			
pa	permit. Departr Imports any init		23a. Parti. Enter the disease, or compl	BON .	L	ELSON FUN ONG NECK	RD, MILLS	SBORO, DI	E.19966	Approximate			
E	cate be executed Medical Examiner the burial-fransit	ıysician/Medicai Examiner	dicai	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a constitution of the constituti	consequence of):	1 Int	evel or			Interval Between Onset and Death		
O POY OO	The law requires that the death certificative has been signed by the attending phy age 2 should be detached for use as the			ysician/Medic	ysician/Medic	ysician/Medic	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy		
as, r	uires that signed b ld be deta	Ď	Part II. Other significant conditions con	tributing to death but	not resulting in the u	inderlying cause give			obacco use contribute Yes 2 \(\subseteq \text{No} 3 \(\subseteq \)	to the cause of death? Probably 4 \times\text{Unknown}			
		Completed			1			24a. Was auto perfo 1 Tes	an 24b. Were prior to death' 2 No 1 Ye	autopsy findings available completion of cause of as 2 No			
<u> </u>	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	la anitale		O#h	26. Place of Deat	th (Check only o	one)				
lon of	ng Phys fter this ineral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1Inpatient 28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injur Wor	4 Nursing no		dence 6 Other (S _k how injury occurred	eecify)			
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (. City or To	Street and Number or wn, State)	Rural Route Number,			
	te Hospit 24 hour 1e Funere letely fille	Medical (examination and/or in				cause(s) and manner date and place, and d				
	To the To the Comp	Me	29b. Signature and title of certifier	7	2000	29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)			
			· ///Jaw	Nence	MI	1)5	11418		MM14,	2005			
	10		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type	Print) Mt. Roya	il Du	Bw Di	way Min	2)2)7			
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 9 2005	32. Registrar	's Signature				,				

State of Maryland / Department of Health and Mental Hygiene 15 3284 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Dorothy Joan HOLLAND 2005 8:29 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1075 Mt. Aetna Road, Apt. 2 Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Qay, Year) Reb. 22, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F 218-26-9637 75 Yrs. Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location worke 10d. Inside City Limits rthen "neturel", or iteme 23s or 28s-f ehov the Medical Examiner must be notified at Director Maryland Washington 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1075 Mt. Aetna Road, Apt. 2 21740 Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filad within 72 hours aftar in Hygiane.
other then "neturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Importent: If Item 27 is marked other th any injury or other treumatic event, the her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B John E. Solloway Maude E. Ottinger ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buddy Glines - son-in-law 127 Catawba Place, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 4/9/05 Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hrrest Priysician ardiopulmonan minutes /Medical Due to (or as a conseque of): Examiner oxonaru THE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit The law raquires that the death cartificate be executed Hyperlipidemia
Due to (or as a consequence of): *ear* Division of Vital Records, P.O. Box 68760, perter Physician/Medical ears attanding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year signed by the a id be datached f 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Heart Failure been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Peripheral Vascular Disease s cartificata has b liractor, paga 2 sl 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours aftar death.
To the Funeral Director: After this cartifica complataly fillad in by the funeral director; p 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Mann Death 28c. Injury at Work? 28b. Time of Certification; 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD0052136 Name and address of person who completed cause of death (item 23a) (Type, Print) Williamsport Ciccarelli urket ruc ١l 31. Date filed (Month, Day, 32. Registrar's Signature State APR 08 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DONNELL T. HOPKINS State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a, pt.II, 27 per me fill at 5 of Deathas Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year onne heron APRIL 2005 :18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL EASTON TALBOT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex Birthplace (State or Foreign Country) Days Months Hours 10 M 2□ F 220-66-3868 8 Yrs. Director Mary Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "neturel", or Items 23e or 28a-f shov treumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director Dorches 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Henr STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ma intenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be Pages 1 and 2 should be in nent of Health and Mental I George ·an 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Oretta Hopkins other t item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Latarin - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Bucktown Cemetery = 5 Department of Importent: If any injury or once. ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HENRY FUNEY 21. Signature of Funeral Service Licensee Home, P. uneral Tinelle 04 ambridge, MD. 21613 510 Washington St. 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician a Hypertensive arteriosclerotic cardiovascular disease /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) /sician and e burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 No 2 No Yes director 25. Was case referred to medical 26. Place of Death heck onl one examiner? Hospital: 1 ☐ Inpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 X Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No investigation after death 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as access.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) OCME APRIL 5, 2005 ompleted cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State Registrar

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State of Maryland	/ Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear Physician 6:00a.M 30,2005 Anna B. Jones March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Kensington Nursing & Rehab Kensington If Under 1 Year
Months Days 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Dec. 21, 1916WashDC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1□M 2QF 88 577 60 5367 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Count Itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at Y☐Yes 2☐No D.C. Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20019 IISA 3760 Minnesota Ave, N.E. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinet once. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: SpecifyBlack 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B.O.G. Currency Examiner 12years none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Branche Ida James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosalie M. Scott / Great Niece 1816 Kenyon StN.W. WashD.C.20010 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State alacal 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 4/5/2005 WashD.C. ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral H 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications (Complications) and the death of the death Approximate Interval Between Onset and Death Immediate Cause (Final EPSIS **Physician** AWEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for as a consequence off Examiner the ettending physicien and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown anoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 NO Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital
within 24 hours al
To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057630 March, 31, 2005 Heun, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arun Anuradh 10301 Silver Spring, MD. 20902 32. Registrar's Signature Ga. Ave. State Registrar

			For State of M	aryland / Dep <i>Ce</i>	partment of Hertificate of L		ental Hygier	4000	13287
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici		WAYNE CLARENO	I Joh	NSON		Month 03	Oay Year	2120 M
	/Medio		4a. Facility Name (I not institution, give street and number	2 00 10	1	Location of Death		tc. County of Death	
1	Examir	ier	la de la cianto	10-60-	Si	1		Willam	100
			5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		219 12-800/2 15M 20F	Yrs.	Months Days	Hours Min.	(Month, Day, Yea	ur) 4 Cou	ntry) MD
			Usual Residence of Decedent			11	0 2000		
	land ow		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Man,	호	MD Wicomico	SALIS	hund				1 X Yes 2 □ No
	th the Marylan or 28e-f ehow e nutified at	Director	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Cou	ntry?
	23a or	0	1014 Queen Avenue,		218	01		11.5A	
	ris 2	Funeral	11 Marital Status 12. Was Deceden	Ever in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	
10	fer of the control of	Ξ	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 2	No.			Hican, etc.)	Black, White	, etc.
036	urs e	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: B/	ACK
5-0036	tiled within 72 hours efter death with the Maryland Hyglene. ther then "natural", or items 23a or 28e-f ehow ther then "natural", or items 23a or 28e-f ehow ent, the Medical Examinat must be notified at	Completed	15. Decedent's Education	16a. Dec	edent's Usual Occup	ation	16b.	Kind of Business/Ir	ndustry
215	nin 7	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	life	re kind of work done of DO NOT use retired	iuring most of workii	ng		
213	d with	mo:	12 2		DISA	bled			
b	othe	Bec	17. Father's Name (First, Middle, Last)	,		18. Mother's Name	(First, Middle, Maid	en Sumame)	
<u>m</u>	should be nd Mental marked c	To B	Clarence Lee Jo	LN SON	1	Elsie.	HUNTE	R	
Maryland 2121	2 should be filed withir and Mental Hygiene. Is marked other then raumatic event, tre Ma		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street a	and Number or Rura	I Route Number, Cit	y or Town, State, Zi	o Code)
Ž	nit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla artiment of Health and Mental Hyglene. cortent: if item 27 is marked other then "natural", or items 23a or 28e-f ehow ortent: if item 27 is marked other then "natural", or items 23a or 28e-f ehow injury or other traumatic event, the Medical Examinat must be notified at injury or other traumatic event.		Clarence L. Johnson - ta	ther 1014	Queen Au	epue SA	lishury.	MO 210	801
Baltimore,	s 1 a f Hei item othe		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place		ate /20c.	Location - City or T	own, State
5	age ent o nt: if		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Flourer	Hill Come	ten 1 4-9	1-05 8	den M	0
	nit. F autmo		21. Signature of Faneral Service Ligensee	10000	22. Name and Addres	s of Facility Re	nie Smit	6 FIH	
B	permit. Pages 1 and 2. Department of Health ar Importent: If item 27 is any injury or other trau) well took		717 10184	Trahella	4 solish	in, MO	21801
			23a. Part1. Enter the disease, or complications that cause	d the death. Do not e	nter the mode of dyin	g, such as cardiac c	r respiratory arrest,	//	Approximate
			shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	ine.	ICEPHAL				Interval Between Onset and Death
	Physician /Medical		resulting in death)	a consequence of):			•		10 DAYS
1	Examiner			GNANT	HYP	ERTEN	510 N		2 WEEKS
		P.	Sequentially liet conditions b.	a consequence of):	<u> </u>				
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury						
	arecu al-tra	ха	that initiated events c	s a consequence of):					
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687	phy:	dic	d						
	eath certific attending p for use as	/We	IF FEMALE: 23c. If yes, outcom					23d. Date of deliv	ery
Вох	that the death cer ed by the attendir detached for use	ciar	in the past 12 months?		I □Ectopic pregnancy i □ Other (specify) □			Month	Day Year
Ö	the d y the ched	iysi	1 Yes 2 No 9 Unknown						
Division of Vital Records, P.O.	that the od by detac	Completed by Physician/Me	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds	tw requires that s been signed b should be det	q p	DNEUMONIA					2 No 3 Pro	bably 4 □Unknown
Ö	v req beer shou	ete	INSULIN DEPEN	DENT	DIABETES	. MELLITO	24a. Was an	24h Were aut	opsy findings available
36	has has	dw					autopsy performed	prior to co	ompletion of cause of
a	icate	ပိ	SEIZURES				1 ☐ Yes 2 ☑	√o 1 □ Yes	2□ No
VIE V	icier certif ecto	Be	25. Was case referred to medical examiner? Hospital:		ont of post Othe	26. Place of Death			
of	Phys this al dir	2	TEMPINDAL		ent 3 DOA	4 Nuising noi	me 5 Residence		fy)
u C	ling After Tuner	Certification;	1 ☑Natural 5 ☐ Pending (Month, D	ay Year) Injury	Worl	Yes 2 □No	200. 00001120 11011 11	july coounica	
Sic	Head Jeath tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	iun. At homo form			28f. Location (Street	and Number or Ru	ral Route Number
Σ	or Alfter of Direction by	rtif		ijury - At home, farm, tc. <i>(Specify)</i>	street, ractory, onice		City or Town, St		arriosto resmoor,
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		200 Continue (EVO-situing Physician Tour	t of my knowledge - 1	ath consumed at the city	no date and least	and due to the com-	(e) and manner co	stated
	Hos 24 ho Fun Fun tely f	Medical	29a. Certifier 1 \(\sigma' \text{Certifying Physician:}\) To the bes (Check only one) 1 \(\sigma' \text{Certifying Physician:}\) To the bes and manner and manner s	of examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, a pinion, death occurr	ed at the time, date a	and place, and due	to the cause(s)
	the the mple	Mec	20h Signatura and title of codifier		29c. License	e number	29d. l	Date signed (Month	Dav. Year)
	To To		lat L	~, M.C	· D	4-69	62 A	PRIL O	4,2005.
			7						
			30. Name and address of person who completed cause of M SHIRAZI, MD. PEN	death (Item 23a) (Typ ハンムレム	e, Print) RFGONA	4 MEDI	CAL CEA	STER. 1	1D21061.
			31. Date filed (Month, Day, Year) 32. Pigis	rar's Signature					
	Sta Registi	ate rar	31. Date filed (Month, Day, Year) 32. F 3is APR 0 6 2005	har a K	Smiles				

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State of Maryland / Department of Health and Mental Hygiene 📗 🥛 🖔 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Lease 4<u>,</u> 10:20 A M April 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13706 Woodland Heights Drive Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F 214-60-0119 Yrs. Director 54 August 5,1950 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Rems 23a or 28a-f show traumatic event, the Medical Examining must be notified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 😿 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 13706 Woodland Heights Drive death v 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Post Master USPS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Richard Lease Martha Duda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Jean K. Lease/Wife 13706 Woodland Heights Dr. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) 14/7/2005 Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Man 16 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Pancrech disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No the 9☐ Unknown 9 Unknown ģ signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No page 2 should 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) meland MO D41667 4.5.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. McCormack, MD 11110 Medical Campus Rd, Hagerstown, MD 32. Prigistrar's Signature 31. Date filed (Month 12) Year) 6 2005 State Registrar

			1 = For State Registrar	State of Ma	ıryland /	-	artment of rtificate of				giene	05	13289
ı	Physici	an	1. Decedent's Name (First, Middle, L				Lovo	L L L L		Month	Day	Year	3. Time of Death 10:54 AM
	/Medic Examin	al	Johnnie 4a. Facility Name (If not institution, g	Eleanor			Love			April		nty of Death	10.54 11
	Examili	eı	Laurel Region	· · · · · · · · · · · · · · · · · · ·	L		Lau				1	e Geo	rge's
	Funeral Director		265-24-5364		(In yrs. last b 36	oirthday) Yrs.	It Under 1 Year Months Days		Min. M	Date of Birt (Month, Day ay 8,	1918	9. Birth Cou Ge	place (State or Foreign ntry) Orgia
	yland iow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To								10d. Inside City Limits
	e Mar	ctor	Maryland Prince	George's		C.	linton				<u></u>		1 ☐ Yes 2¥☐¥No
	with th	Funeral Director	10e. Street and Number 12043 Birchview	Drivo			10f. Zip Code 207	25			10g. Citizen USA		ntry?
	ns 23	eral	11. Marital Status	12. Was Decedent E	ver in U.S.	13.			igin? (Specif	fv Yes or No-		Race - Ameri	can Indian.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, Ire Maricel Eventral in a final te mullified at ances.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ 10 ivorced	Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates:	e e		Was Decedent of If Yes, specify Cu 1 ☐ Yes XIX No			can, etc.)	1	Black, White, cify: B1a	
2-0	72 ho	eted	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usual Occu	during mos	st of working		16b. Kind of	Business/In	dustry
121	within ene. than	Completed by	Elementary/Secondary (0-12)	5+ College (1-4or 5-	+)	life.	<i>DO NOT u</i> se retir cher	9d)			Public	Schoo	ols
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ylar	ould by Menta arkad atic e	To E	Benjamin Harr						lissa				
, Mar	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship Wanda Lovette /		19	b. Maili 2043	ng Address (Stree 3 Birchv	iew Dr	er or Rural F Live C	Route Numbe linton	, City or Tow , Mary	vn, State, Zip 1and	20735
Baltimore, Maryland 21215-0036	Pages 1 nent of He int: If itar		20a. Method of Disposition 1 Darial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		cemet	ery, crei	esition (Name of matory or other pl t Cemete		Dat April		20c. Location Davids		
Balt	permit. Departn Imports any inju		21. Signature Juneral Service Lic	alas h	2	22	2. Name and Addi	ess de acui	ge P.	Kalas	Funer	al Hor	ne PA and 20745
г			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each lin	the death. Do							1.02 / 1.0	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Aspira	ation Pne	eumon	iia						Onset and Death
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	ocuted nd transit	Examiner	that initiated events	C.	ac Arrhyt								
8760,	cate be executed physician and the burial-transit	cal Ex	resulting in death) Last	Due to (or as a Critic	al Aort	,	enosis						
9	ing ph	Medi	IF FEMALE:										
P.O. Box	The law requires that the death certificate be executed to has been signed by the at ending physician and hage 2 should be detached for use as the burial-transit	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2010 You	23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown	2 🗌 Fetal dea		Ectopic pregnand Other (specify)	Э				Date of delive Month	ery Day Year
S, P.	s that the ned by a detact	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting	in the u	nderlying cause g	ven in Part I	ı.	23e. Did to	bacco use co	ontribute to t	he cause of death?
Sign	w requires been signe should be	ted k	Osteoporosis	1 D C1 D:						1 □ Y	es 2□No	3 ☐ Prob	babiy XXUnknown
Division of Vital Record		Completed	Gastroesopna;	geal Reflux Di	.sea.se		·			24a. Was autop perfor 1 Yes	med?	prior to co death?	ppsy tindings available mpletion of cause of
/ita	Physician: this certificatal director, I	Be (25. Was case referred to medical examiner?	Hospital.					e of Death (0	Check only o	ne)		
of	Physi r this c ral dir	P.	1 ☐ Yes 2 🗓 No 27. Manner of Death	Hospital: 1 Anpatier		Outpatier . Time o	IL SELDON		-		lence 6 0		ý)
ion	Attanding of death. actor; After by the funer	atlon	1 登 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day	Year)	Injury	W	ork?]Yes 2□		a. 50001150 11	ow injury ood	arro d	
Divis	il or Attandin after death. I Diractor; Af d in by the fur	ertification;	3 Suicide 6 Could not determine		ry - At home, . (Specify)	farm, str	eet, tactory, office		281	t. Location (S City or Tow		mber or Rura	al Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor; After th completely filled in by the funeral	edical C	29a. Certifier 1 Sertifying F (Check only one) 2 Medicel Exc	Physicien: To the best of eminer: On the basis of and manner stat	examination a	ge, death and/or in	h occurred at the vestigation, in my	ime, date ar opinion, dea	nd place, and ath occurred	d due to the o	cause(s) and date and plac	manner as s e, and due to	tated. o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	· · · · · · · · · · · · · · · · · · ·	006:			se number		2	29d. Date sig		
•	(2)		▶ Padmay					4174			412	12005	
ر ا	(3)		30. Name and address of person where Padmaja S. Ud	dapi MD	7350 Va	an D	usen Rd.	#380	0 Laur	el, Ma	arylano	1 2070	7
•••	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 20	Registra Registra	r's Signature	for	W						

Lerri mae, Clayth 221-14-5888
Baltimore, Marvland 21215-0036

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	t		1- State Registrar amended i		laryland / Depa Ce chd/may 4-6				Reg. No.	005	13290
1	Physici	an	1. Decedent's Name (First, Middle, Thomas Clayton	Last)				2. Date of De Month	Day	Yea	
	/Medic	al	4a. Facility Name (If not institution,			Jr.	or Location of Death	04	03 4c. 0	County of De	0/23 M
	Examin	er	0	/ - O - / -	1 600 100	50. City, 10 Mil,	-4 /			Vicon	
Ī	Funeral Director		5. Social Security Number 6 221–14–5898	157M 2□F	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 9/4/19	th y, Year)	9. 8	inthplace (State or Foreign Country) ryland
	p ,		Usual Residence of Decedent		100 City Town only	nesting.					10d. Inside City Limits
	farylar show	ō	10a. State 10b. County Maryland Wico	mi co	Salisbur						1 X Yes 2 No
	with the h	i Direct	10e. Street and Number 307 Mill Pond,		Sarrada	10f. Zip Code	804		10g. Citiz	en of What	Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, II a Modical Examinating at the incilling a	by Funeral Director	11. Marital Status 1 Never Married 2 Marrier 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	₩No	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto I Specify:	cify Yes or No Rican, etc.)		4. Race - Ar Black, Wi Specify:	nerican Indian, hite, etc. white
2-00	72 hou natura	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occu	pation during most of working d)	ng	16b. Kin	d of Busines	ss/Industry
21215-0036	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or	3+)	& Die Ma			Cro	wn Coi	rk & Seal
CA	Hygie Hygie Sther		12 17. Father's Name (First, Middle, La	ist)	1001	d DIC III	18. Mother's Name	(First, Middle			EN G DCGE
an	nould be filed within the Mental Hygiene. Darked other then natic event, If a Mental Market.	To Be	Clayton W. Larr	imore Sr.			Rose Co	nnelly			
<u>a</u>	2 should and Meni Is marka	-	19a. Informant's Name/Relationshi				t and Number or Rura				
Σ 	and 2 lealth m 27		Irene V. Larrim	ore/wife			nd,Apt. 14	6,Salis			
Baltimore,	8 2 = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 1 □ Conation 5 □ Other (Special Control Con		20b. Here & Aisp Combine, cre Union Gr Church C	eemback t				-	or Town, State Ville, VA
Balt	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service	lina (ESP	H 5	2. Name and ddr Olloway 01 Snow 1	Funeral Ho Hill Rd.,	me Proi Salisbu	fessi	onal 1 MD 218	Association 304
ĺ	Physician		23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	line.	iter the mode of dy	ing, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death 5 year
Г	/Medical Examiner			Due to (or a	s a consequence of):						
١,	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):			·			
60,	be executed ician and burial-transit	ai Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):						
687	physi physi s the b			d							
P.O. Box (The law requires that the death certificate b tie has been signed by the attending physic age 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	_Ectopic pregnand ☐ Other (specify)	су	···	2:	3d. Date of o	delivery Day Year
	uires that the signed by d be detact	by	Part II. Dther significent condition	s contributing to death	but not resulting in the u	underlying cause g	iven in Part I.	1	tobacco us	_	to the cause of death? Probably 4 _Unknow
Records,	The law requir ate has been si page 2 should	Completed						24a. Was auto perfo 1 ☐ Yes	psy prmed?	prior t death	autopsy findings available o completion of cause of essential 2 No
Vital		a	25. Was case referred to medical				26. Place of Death				63 20110
<u> </u>	y s	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpa	tient 2 ER/Outpatie	int 3□ DOA O	ther: 4 🗆 Nursing Hor	me 5 ☐ Res	idence 6	□Other (S	pecify)
Division of	Attending Phir death. ector: After the by the funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	ition	njury 28b. Time o Day Year) Injury	W	uryat ork? ⊒Yes 2 □No	28d. Describe	how injury	occurred	
Divis	al or Atte s after de s Directo d in by th	Certification:	3 Suicide 6 Could not determine	286. Place of I	njury - At home, larm, st etc. <i>(Specify)</i>	treet, factory, office	•		Street and wn, State)	Number or	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To tha Funeral Director: After th gompletely filled in by the funeral	edicai	29a. Certifier 1 Certifying (Check only one) 1 Medicel E	Physicien: To the bes xaminer: On the basis and manner:	st of my knowledge, dea of examination and/or in stated.	th occurred at the nvestigation, in my	time, date and place, a opinion, death occurr	and due to the ed at the time,	cause(s) a date and	and manner place, and d	as stated. lue to the cause(s)
	To the He within 24 To the Fe	M	29b. Signature and title of certifier				nse number				onth, Day, Year)
			> magrah				05/359		MPRIL	. 3rd	2005
	6/11/0		30. Name and address of person w				SAUSBUKY	MAS	18011		
	St	ate	31. Date liled (Month APR YOU)	32. P git	S-S.DIVISIO Strar's Signature	14 31	14313419	7.10	, , , ,	•	
•	Regist		APR U	ZUUS ALA	on & s	park					

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of He rtificate of D	ealth and Me Death			13291
	Physici	an	1. Decedent's Name (First, Middle, Last	, 5	,			Reg. I 2. Date of Death Month	Day 5 + Year	3. Time of Death
	/Medi	cal	Alfred 4a. Fecility Name (If not institution, give		10	4b. City, Town, or	Location of Death	april	200 S	//: 20 AM
	Examir	ier	Shady Grove Adver		1		ville		Montgo	
	Funeral Director		5. Social Security Number 6. Se	M 2□F	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign intry)
	D		Usual Residence of Decedent	89				Oct. 31,	1915 A	AZ
	farylar show	ō	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-i	Director	MD Montgome 10e. Street and Number	ry	Gaith	ersburg 10f. Zip Code		10g. (Citizen of What Cou	
	ath with		106 Meem Avenue			2	0877		United St	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy introductant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy introductant: If item 27 is marked other than "natural be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give		Was Decedent of His f Yes, specify Cubar 1 X Yes 2 No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify:	
9	2 hour	ted b	15. Decedent's Edu	Year or Dates: WW cation	16a, Deced	dent's Usual Occupa	tion	lexican 16b.		nite ndustry
21215-0036	within 7 ene. then "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. l	kind of work done du DO NOT use retired)	uring most of working	Na		stitute of
ק טר	e filed at Hygi other vent,	Be Co	17. Father's Name (First, Middle, Last)		Ch	ief Engin	eer 18. Mother's Name (i			. 10011
ylaı	Menta Menta Marked Marice	To E	Virgil Lopez				Celesti		cale	
Ma	nd 2 st tith and 27 Is n r traun	8	19a. Informant's Name/Relationship (T) Stephen A. Lopez /	, ,			nd Number or Rural F st Place,			
ore,	of Head Mitem		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ F	20b.	Place of Dieno	cition (Nama of	Dot	e 20c.	Location - City or To	
Baltimore, Maryland	it. Pag intment intent: injury o		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Life 1		cropell	natory or other place tan matory	April 200		exandria,	Virginia
Ba Ba	Department of the services of		TRACYA TO	0			of Facility De V Drive, Gai			
			23a. Part1. Enter the disease, or complete shock, or heart ailure. List only or	e cause on each line.		er the mode of dying	, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons-	CPSiS					3 days
	Examiner		Sequentially list conditions.).						
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Underlying C	Due to (or as a conse	qu <i>e</i> nce of):					
90,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	i Exa	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
68760	tificate I og physi as the b	edicai								
Вох	attending	lan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet		Ectopic pregnancy			23d. Date of delive	,
Р. О.	t the de	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5□	Other (specify)			Month	Day Y <i>e</i> ar
<u>s</u>	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause giver	n in Part I.		use contribute to the	
Records,	v requi	eted								ably 4 aUnknown
		Completed						24a. Was an autopsy performed?	prior to con death?	psy findings available mpletion of cause of 2 No
Vital	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:	758/0-1	Othon	26. Place of Death (C			
n of	ding Phy h. After this funeral d	H .	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 □ DOA Outer 28c. Injury a Work?		5 Hesidence I. Describe how inj	6 □Other (Specifi ury occurred	/)
Division	or Attendi after death. Director: A d in by the fu	flcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm stre	M 1 □ Ye	es 2 No	Location (Street	and Number or Rura	/ Davida Number
2	ital or / irs after ral Dire led in b	Certification;	4 ☐ Homicide determined	building, etc. (Speci	ify)	ot, lactory, office	201	City or Town, Sta	te)	r Houte Namper,
	To the Hospital or Attending Physician: within 24 hours after death To tha Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 ► Certifying Physical Control Check only one)	icien: To the best of my kn er: On the basis of examin- and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my opin	, date and place, and nion, death occurred	I due to the cause(at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier	1		29c. License r		29d. D	ate signed (Month,	Day, Year)
	1211	-	30. Name and address of person who co	mpleted cause of death (Ita	m 23a) (Type 5		49	apr		2005
			Christine Le	poutre, 9	901 Med		er Drive,	Rockvill	e, MD 208	350
	Stat Registra		31. Date filed (Month, Day, Year) APR 0 4 20	32 Registrar's Sign		nello				

			1 - For State Registrar AMENIN TO	State of Maryla	_		ealth and Mental Hy Jeath	/gierie 0 0 5	13292
			1. Decedent's Name (First, Middle		. 00-12	4/ 20/ 07 Ju	2. Date of D		3. Time of Death
	nysici Medic		ARTHUR	LAMBERT		LAWSON	APRIL	3, 2005 Yea	10:50P M
	xamin		4a. Facility Name (If not institution	give street and number)		4b. City, Town, or L	ocation of Death	4c. County of De	ath
			FREDERICK ME			FREDERIC		FREDER	
	neral ector		5. Social Security Number 578–16–8972	6. Sex 1 ★ M 2 □ F 7. Age (In yrs	i. last birthday, Yrs.	Months Days	Hours Min. 8. Date of Bi (Month, D		irthplace (State or Foreign Country) 'yland
pu	12:270		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or L	ocation			10d, Inside City Limits
faryla	E E	ō							1 Yes 2 No
the N	all of	Director	Maryland Frede	rick	1.	amsville		10g. Citizen of What	Country?
with	4	Ö	3419 Green Va	11ev Road		21754		U.S.A.	Journay:
Jeath	8	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.		panic Origin? (Specify Yes or N		nerican Indian,
72 hours after death with the Maryland natural: or Items 23a or 28e-f show	injury or other traumatic event, the Medical Examiner must be notified at 8.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?			panic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	Black, Wil	nite, etc.
P hou	B		15. Decedent	AA AA	16a, Dece	dent's Usual Occupati	ion	16b. Kind of Busines	s/Industry
7 ui 7	Wedlin	ompleted	(Specify only highes	t grade completed)	(Give	kind of work done du DO NOT use retired)	ring most of working	Too. King of Eddings	arii dadii y
U C I C I filed within Hygiene. ther then "	94	E	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Own	ner/Operato	or	Surgical	Supplies
thys effects	ant,	0	17. Father's Name (First, Middle, I	ast)	1		8. Mother's Name (First, Middle		Варричев
ytarra buld be fill Mental Hy erked oth	ic e	0 8	Ivan Thompso	n Lawson			Ethel Linthic	cum	
2 should be filed withing and Mental Hygiene.	ma	-	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ng Address (Street an	d Number or Rural Route Numb	per, City or Town, State	Zip Code) 21754
Tand 2 si Health an lam 27 is r	er tra		Grace Evelyn La	wson - Wife	3419	Green Va	lley Road, Ija	amsville, M	aryland
Dallinore, Legential Pages 1 and Department of Healt Important: If Itam 2	othe		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - City of	or Town, State
Darill Pages Department of I	ry or		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc				etery 4/7/05	Damascus,	Marvland
mit.	in in		21. Signature of Funeral Service				of Facility esworth P.A., I		
	any		NOTOTAL &	Hilliam	2 05	in L. Mole	esworth P.A., I Road, Damascu	Funeral Hom	e d 20872
			23a. Part1. Example disease, or	complications that caused the dea only one cause on each line.	ath. Do not en	ter the mode of dying,	such as cardiac or respiratory a	arrest,	Approximate
Physic	oion		Immediate Cause (Final	/	1 12	the same of			Interval Between Onset and Death
/Mec			disease or condition resulting in death)	a. Due to (or as a post e		art tailer			
Exam	iner			1	Vocatensi	Λh			
		ē	Sequentially list conditions,	b. Due to (or as a conse					-
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G					
exec on an	ial-tr	Exa	resulting in death) Last	Due to (or as a conse	quence of):				
te be e	ng e	cal		d.					
tifical g	as #								
h car	should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy		23d. Date of d	elivery
deatt	od for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of		Other (specify)		Month	Day Year
t the	tache	hys	9 Unknown	9□ Unknown					
s tha	e de	by P	Part II. Other significant condition	ns contributing to death but not re	sulting in the u	nderlying cause given	in Part I. 23e. Did	tobacco use contribute	to the cause of death?
w requires to been signe	pind	ed	Atrial hbrillation					Yes 2 xxx lo 3⊡1	Probably 4 Unknown
law re	2 sho	Completed					24a. Was		autopsy findings available
The I	age 2	mo						ormed?/ death?	
iclan:	tor, p	a)	25. Was case referred to medical				1 ☐ Yes 26. Place of Death (Check only o		2 2 1 1 1 4 0
ysich	direc	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatier	Other			ecify)
ding Physician: The h. After this certificate	funeral director, page	n:	27. Manger of Death	28a. Date of Injury	28b. Time o			how injury occurred	outy
. A	e fun	atlo	1 Natural 5 Pending 2 Accident investig		Injury		s 2 No		
Attending r death.	by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	hed 286. Place of injury - At I	nome, farm, str	eet, factory, office		Street and Number or F	Rural Route Number,
s afte	in be	Sert	4 - Hollicide	building, etc. (Speci	iry)		City of 10	wn, State)	
DIVISION OF VICE THE PROPERTY TO THE HOSPITE OF THE PORTION OF THE PROPERTY OF	completely filled in		29a. Certifier 1 Certifying	Physician: To the best of my kn	owledge, deat	n occurred at the time,	, date and place, and due to the	cause(s) and manner a	is stated.
he H in 24 he F	plete	Medical	one)	xaminer: On the basis of examinand manner stated.	ation and/or in	vestigation, in my opin	nion, death occurred at the time,	date and place, and di	ie to the cause(s)
To t with	COM	Σ	29b. Signature and title of certifier			29c. License r		29d. Date signed (Mor	nth, Day, Year)
×'			J. Munen,	M.D.		Dog	055793	4/4/0	15
5			30. Name and address of person v	Mocompleted cause of death (Ite	m 23a) (Type,	Print rederick Men	norial Hospital		
Re	Sta egistr		31. Date filed (Month, Day, Year)	32. Beristrar's Sign	ature	Land .	norial Hospital		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		State of	Marylar		artment of rtificate o			ental Hy	giene Reg. No.	05	13293
			1. Decedent's Name	(First, Middle, La	st)						2. Date of De	eath		3. Time of Death
	Physic /Medi		Otto A.	Moore						Δ	Month pril	O ₂	2005	4:10 am
	Exami		4a. Fecility Name (If			er)		4b. City, Town	or Location		ргтт		unty of Death	
			Washingt	on Adv	entist	Hosni	ta1	Takoma	Park	-		Mor	ntaom	arv
	Funeral		5. Social Security Nu	ımber 6. S	ex 7.		last birthday)	If Under 1 Yea	r If Under		8. Date of Bi		9. Birth	nplace (State or Foreign
	Director		239-48-0	059	M M 2□F	73	Yrs.	Months Day	s Hours		oct 0			olina
	ף ,		Usual Residence of I											
	the Maryland r 28a-f show	_		10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Ba-fs	cto	Md.	Prince	George	La	rgo							1X Yes 2 ☐ No
	ith th)ire	10e. Street and Num	ber				10f. Zip Code				10g. Citizen	of What Co	untry?
	23a	<u>e</u>	500 Nort	h Harry	S.Trum	nan D	r. [#] 10'	7 20774	1		-	USA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Mudical Examinat must be notified at	Funeral Director	11. Marital Status		12. Was Decede	ent Ever in U		Was Decedent of If Yes, specify Cu	Hispanic Or	rigin? (Spec	cify Yes or No		Race - Amer	
9	afte or it	民	1 Never Marrie	_	1 Tes 2			1 □ Yes 2 <mark>X</mark> N			110an, 6(0.)		Black, White	
5-0036	iral',	d by	3 Widowed 4	Divorced	Year or Date	s:		100 2014	o specify.	•		Sp	ecify: B1	ack
5	72 hours "natural",	Completed	(Specif	15. Decedent's Ed by only highest gra	lucation de completed)		(Give	dent's Usual Occ kind of work don	e durina mos	st of working	a	16b. Kind	of Business/I	ndustry
2	within ene. than	du	Elementary/Secon	dary (0-12)	College (1-4	or 5+)	life.	DO NOT use retii	red)		,		_	
2	ed w ygier ygier ti,	Ö	7th_				Baker						Indus	try
Maryland	should be filed within and Mental Hygiene. 8 marked other than aumatic event, I to Mark	Be	17. Father's Name (F						18. Moth	er's Name ((First, Middle	, Maiden Sui	mame)	
<u>yla</u>	should be and Mental a marked o	2	Samuel N	Moore					Magg	gie	Lee			
a	2 sho and is my		19a. Informant's Nar	me/Relationship (Type, Print)		19b. Mailir	ng Address (Stree	et and Numb	er or Rural	Route Numb	er, City or To	wn, State, Z	ip Code) 20774
	1 and 2 Health tem 27 i		Jessie N	Moore (Wife)		500 N	Jorth H	arry	S. I	rumar	n Dr.	#107L	argo, Md.
ore	of Heritan		20a. Method of Dispo				Place of Dispo	sition (Name of natory or other pi		Da			on - City or T	
Ĕ	Pages nent of int: if it iry or o		'4 □ Donation 5		Removal from Sta	IIB I		Mem P	· .	pri1	8,05	Lando	over.	Md -
altimore,	permit. Pages 1 an Depertment of Heal Important: if item 2 any injury or other once.	1	21. Signature of Fun	eral Service Licer	se			. Name and Add					,	
m	Depermine Depermine Bright Important Properties Bright Imp		this	mo	A. MA	una		rone J	Vol	ina 7	110 1/2	nnod	C+	NW 20011
			23a. Part 1. Enter the shock, or heart	e disease, or con	olications that cau	sed the deap	Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory a	rrest,	y St.	Approximate
			Immediate Cause (F		one cause on each	n line.		0 02						Interval Between Onset and Death
	Proysician /Medical		disease or condition resulting in death)		a. ack	alle	of C	rdion	140 pe	thy				years
В	Examiner				Due to (or	as a consec	uence of):	ardion anyloi	6 %	/				
		-	Sequentially list cond	ditions,	b. Overto for	Lacra,	Course off	anylor	cologis	ŕ				years
	ted	Examiner	d any, leading to inition cause. Enter Underline Cause (Disease or in	lying	200 (0 (0)	as a consec	deriod or).	/						
_	ficate be executed physician and is the burial-transit	хаг	that initiated events resulting in death) La		c. Due to (or	as a consec	uence of):							
68760,	be e ician buria													
87	cate phys	edical			. d								_	
			IF FEMALE:		22c If you outcom	ma al araga								
Box	The law requires that the death certivite has been signed by the attending tage?	Physiclan/M	23b. Was decedent p in the past 12 m		23c. If yes, outcor 1☐Live birth	2 Feta	Ideath 3	Ectopic pregnan	су			23d.	Date of deliv	rery Day Year
o.	that the de ned by the a detached	/sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4□Pregnani 9□Unknowr		eath 5∟	Other (specify)						Duy
9	d by detac		Part II. Other signific	ant conditions o	antributing to doot	- h	. No and the state of the state				00- 01-4			
S,	res tha signed be del	b	ait ii. Other signing	ant conditions (onthibuting to death	1 Dut not 195	uiting in the ur	iderlying cause g	Iven in Parti					the cause of death?
ecords,	w requir been si should	ted				-					1	Yes 2∐No	o 3∐Pro	bably 4 XUnknown
ec	e law has b	Completed									24a. Was		b. Were auto	opsy lindings available empletion of cause of
æ		, or									perfo	rmed?	death?	
ita	icien: Th certificate rector, pag	Be (25. Was case referre	ed to medical					26. Place	of Death (Check only o			10.70
of Vital	Ø 2 0	ToE	examiner? 1 Tes 2 N	lo	Hospital: 1 Inpa	atient 2	ER/Outpatien	3 DOA O	thor			dence 6 🗆	Other (Speci	fv)
			27. Manner of Death		28a. Date of I	njury Da <i>y Year)</i>	28b. Time of	28c. Inju				now injury oc		
jo	Attendin death. ctor: Aft y the fur	atlo	1 XNatural 2 ☐ Accident	5 Pending investigation		Jay (Bai)	Injury		Yes 2	No				
Division	or Attending after death. Director: Aftel in by the fune	Certification:	3 Suicide	6 Could not be determined	28e. Place of	Injury - At h	ome, farm, stre	et, lactory, office)	28	f. Location (S	Street and Nu	ımber or Rur	al Route Number,
Ö	el or A after I Direc d in by	ert	4 🗀 Admicide		bullaing,	etc. (Specif	<i>y</i>)				City or Tov	vn, State)		
	spit		29a. Certifier 1	Certifying Ph	ysician: To the be	st of my kno	wledge, death	occurred at the	time, date an	id place, and	d due to the	cause(s) and	manner as s	stated.
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only 2 one)	Medical Exam	iner: On the basis and manner	of examina	tion and/or inv	estigation, in my	opinion, dea	th occurred	at the time,	date and place	ce, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and til	tle of certifier	1			29c. Licen	se number			29d. Date sig	ned (Month.	Day, Year)
	ان مط < سا		10	W	10			n	21	111				
0	(2)		30. Name and address	1 COTTO	nomplated assess	f dooth //-	020) CE	20101)	221	//		M	irex.	3 2005
K	9								7*		00=	0.0		
	CAS	† o	31. Date liled (Month)	Day, Year)	ID. 8100	Strar's Signa		K Ka. I	JanHa	m, MD .	207	U6		
	Sta Registr			0 5 200			Spa	.						
					Man	U	Lane.	a)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MOORE **Physician** Day Year JETOME /Medical APRTL 2005 :58P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LAPLATA

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. CIVISTA MEDICAL CENTER CHARLES 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth Month, Day, Une 23 Birthplace (State or Foreign Country)
 MONTIGAR 1**№**M 2□ F 218-86-530 June Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Examinant must be multiped at 10d. Inside City Limits Directo Prince 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 death Completed by Funeral 20743 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural, any injury or other traumatic avant. Its Medical Fea Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Floor 411ison Floors Tinisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Marlbon Dandb 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 28a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 8 Keshraction US 21. Signature A Frogral Service License 22. Name and Address of Facility 20608 Threm 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespictions, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Omnal 12 /Medical Due to (or as a consequence of): Examiner squartitative interest any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PQ P 3 Probably Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 autopsy performed 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death
| Diractor: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funeral C filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar

completely

DANIEL M. HOWELL, MD 31. Date filed (Month, Day, Year) APR 0 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certi

29c. License number

D-02975

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? 13295 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2005 04 8:30 A M SARAH ELIZABETH MCGINNIS 04 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** SALISBURY WICOMICO 401 ATLANTIC AVENUE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 03-19-1916 Birthplece (State or Foreign Country)
 DELAWARE 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗘 F 89 222-09-1840 Director Usuel Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County r then "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director SALISBURY WICOMICO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 401 ATLANTIC AVENUE Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if tiem 27 is marked other then "naturel", or its important: if tiem 27 is marked other then "naturel", or its wellight or other traumatic event, the Medical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: WHITE þ 3 \ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 8 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM O'NEAL BEULAH MARVEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29455 WEST LINE ROAD, DELMAR, MARYLAND 21875 RONNIE MCGINNIS-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 N Burial 2 ☐ Cremation SPRINGHILL MEM.GDNS. 04-06-2005 HEBRON, MARYLAND 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses lelisa 705 EAST MAIN SIKEET, SALISBURY, MARYLAND 21804 23a. Page. Enter the disease, or complications that caused the 2-ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andio vasalar **Physician** 20 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has lirector, page 2 1 Yes 2 No or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 024986 /md MO 30. Name, and address of person who empleted cause of death (Item 23a) (Type, Print) Reverside Dr. Biol Salisbury and 21801 Bobert mo 32. Figistrar's Signature 31. Date filed (Month, Day 6 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

ORIGINAL

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	/Medic Examin		4a. Facility Name (If not institutio	n, give st	reet and nu	mber)			4b. City, To	own, or Lo	ocation of Deetl	h		4c. County	of Death		
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/ar	ore, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryla ft Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Modeal Examiner must be notified at		19a. Informant's N									d Number or Ru				State, Zip	Code)	
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P.O. Box 6876	or Attending Physician: The law requires that the death certificate be executed after death. stifer death. inclore: Atten this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical			d.													
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Division of Vital Records,	or At after of Direction by	ertif	4 Homicide		mined	build	ding, etc.	(Specify)	ırıı, sır	et, ractory,	Office		City or	Town,	State)	37 07 71071	27 7 10010 7 101	11001,
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 BETTY RUTH MURRAY MARCH 31, 1:39 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL WESTMINSTER 102 TIMBER RIDGE DR., APT. 107 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 280 F 80 /6/1925 Director 216-20-7172 MARYLAND Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28e-1 show traumatic event. It a Medical Examinar must be notified at WESTMINSTER 1X Yes 2 No CARROLL Director MD. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with DR., APT. 107 21157 USA 102 TIMBER RIDGE Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2公 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: WHITE þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Powell Burton Clara Minnetta Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 is - FRIEND 2605 JEFFREY LORI DR., FINKSBURG, MD. 21048 NANCY DENGLER other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ALL COUNTY CREMATION 4/1/05 SYKESVILLE, MD. permit. Page Department of Important: If any injury or once. injury or A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Lig 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, broomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listenly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4 Montos Concer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispase or injury Due to (or as a consequence of) Examiner certificate be executed burial-transil Cause (Disease or injust that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Opstrictive 3 Probably 4 □Unknown Pulmonor 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. a Funerel Diractor: After t Certification: 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funerel D 29a, Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI D0059943 MM(March 31,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Sprer Are. 425minster lown C. 295 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Glow & Spark APR 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Eleanor Grace McLaughlin **2005** 5, April 4:18 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Avalon Manor Hagerstown 8. Date of Birth (Month, Day, Year)
Jan. 22,1927 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 218-24-1870 78 Director Maryland Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28e-1 show any injury or other traumatic event. It is Next be notitied at once. 1 ☐ Yes 2 🖺 No Maryland Washington Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 11222 Lakeside Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ Specify: white 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) secretary car dealer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Thompson Grace Wimmer ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Summers - niece 1736 Edgewood Hill Cir. #104, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hagerstown Crematory 4/6/05 Hagerstown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10110 disease or condition resulting in death) Dyalin /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2□ No 1 Yes 1 Tes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2√2No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours a TC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 052323 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Monta PRYO) 6 2005

5H-10

Dr. Farid Murshed, 1109 Lindsay Lane, Hagerstown, Md. 21740

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Frances Viola McCullough 6:31 pol 2005 /Medical 1 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 21XF Months Director 220-46-0899 81 July 15 1923 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Executar transt be notified at 10d. Inside City Limits Maryland Washington Hagerstown Directo 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 Broadway 21740 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is markad other than "natural", or iter 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 □ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Homemaker</u> Personal Residence permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is markad othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John W. Shupp 2 Mazie Moore Shupp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilson S. McCullough 135 Broadway Hagerstown Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem Park April 7 05 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Much 1331 Fastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician D. Neumonia /Medical Due to (or as a consequence of): **Examiner** Obstruc raguic Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit SKESIS that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3□ DOA 28a. Date of Injury (Month, Day Year) the funeral Certification: 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No **Diractor**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral I 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) opa ARID MURSHED WE 100 N 1100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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State of Maryland / Department of Health and Mental Hygiene 05

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Baltimore, Maryland 21215-0036

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Registrar DHMH 17 Rev 1/2001

		•	For State Registrar	State of Marylar		irtment of l			giene () () 5	13302
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day Year	3. Time of Death
	Physici /Medic		Jeffrey M. Ow	ens				March	31, 2000	5/30p M
7	Examir		4a. Facility Name (If not institution, give s	treet and number)	10	4b City, Town	or Location of Death	6 1	4c. County of Dea	ith
			Maryland Grer	eral Hos	pital	Balti	more (179	Baltimor	
п	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birtl (Month, Da)	y, Year) 9. Bir	thplace (State or Foreign ountry)
	Director		578-70-7643	52				Sept. l	, 1952 Was	hington, DC
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Madfeal Examinat notified at		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	the Marylan 28s-f show notified at	tor	MD Baltimore	В	altimor	e				1 ☑ Yes 2 ☐ No
	or 282	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a c		11 West 20th Stree	t #3u		2121	18		USA	
	ems ems	Funerai	11. Marital Status	2. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
9	urs after death v al', or Items 23e	F	1 Never Married 2 Married	1 ☐ Yes 2 ANo If Yes, Give		☐ Yes 2⊠ No				
21215-0036	72 hours "natural",	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: Bla	ck
77	"nat	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occu kind of work done	pation during most of work ad)	ing	16b. Kind of Business	Vindustry
12	withir ane. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)		Janitor	50)		Private	
	filed Hygid Sther	e Co	17. Father's Name (First, Middle, Last)			<u> </u>	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
an	d be ental ced o	00	Unknown					nce Owen		
Maryland	is 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Ms	2	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Stree	t and Number or Rui	al Route Numbe	r, City or Town, State,	Zip Code)
\\$	and 2 : ealth ar n 27 is ier trau		Kevin Williams		unkno					
ē,	of Health of Health item 27 I		20a. Method of Disposition		Place of Dispos	sition (Name of		Date	20c. Location - City or	Town, State
Baltimore,	o ∪ ← <u>-</u>		1 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State		natory or other pla Cemetei	l l	7 2005	Washingto	n DC
	permit. Pag Department Important: I any injury o		21. Signatine of Funeral Service License							Funeral Home
ä	Departr Departr Imports any inju		1/00 ha-/	1 Chart	_ 7	16 Kenne	edy St. NV	V Washin	gton, DC 2	0011
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only on	ations that caused the dea	th. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final	e cause un each line.	8/10	CK				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):					
100	Examiner			Poeum	onia					
L.,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events							
ó	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	taw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-trans	dicai								
9	ing pl		IF FEMALE:							
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3 🗆	Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
	the all	Physician/Me	1 Yes 2 No	4□Pregnant at time of a 9□Unknown	death 5□	Other (specify) _			IVIGITAT	Day Tour
P.0	that the di ed by the detached		Part II. Other significant conditions con	tributing to death but not re-	sulting in the ur	derhing cause o	van in Part I	23e Did to	bacco use contribute t	o the cause of death?
Vital Records,	ires tha signed d be det	Completed by	Lumphoma	Adult Re	250:100	tory 1	15tees 5			robably 4 Dunknown
9	w require been si should b	etec	Supplier	700	, , , ,	5	7,37,-23			
3ec	has the 2 s	npi	synor one					24a. Was a autop perfor	sv prior to	utopsy findings available completion of cause of
1	pa ate							1 ☐ Yes	2 No 1 ☐ Yes	2 □ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		0+	26. Place of Deat			
o	S T	T0	1 Yes 2 No	1 Mainpatient 2	28b. Time of	t 3□ DOA 28c. Inju			ence 6 Other (Spe ow injury occurred	ecify)
L		lon	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?	28d. Describe II	ow injury occurred	
100	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	lome farm eter			28f Location /S	treet and Number or R	ural Route Number
Division of	or A after Direction by	Certification:	4 Homicide determined	building, etc. (Speci	ify)	et, ractory, office		City or Tow		ura moute mumber.
	Hospital 4 hours 8 Funeral tely filled		29a. Certifier 1. Certifying Phys	icien: To the best of my kn	owledge death	occurred at the t	ime date and place	and due to the d	ause(s) and manner a	s stated
		edicai	(Check only 2 Medical Examinone)	er: On the basis of examinand manner stated.	ation and/or inv	estigation, in my	opinion, death occur	red at the time, o	date and place, and du	e to the cause(s)
	o the	Me	29b. Signature and title of certifier	7 11/~			se number		29d. Date signed (Mon.	
	P > F 0		Edwards Whode	abadon l' Mus		P	39476	, .	3/31/05	
0	[30. Name and address of person who co	mpleted cause of death (ite	m 23a) (Tvne	Psint)	, ,		1	1 0
1-	(2)		Eduardo Mirke	1es m.D.	4011	lakylas	39474 nd Gen	eral	Hospit	al
	Sta	tė	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature _	•			/	
	Registr	4.	APR 0 5 2005	Book #	good					

		1 - For Stete Registrar 1. Decedent's Name (First, Middle, Las.	State of Marylar		artment of H		Mental Hy	Reg. No.	005	3 3 0 3
Physici /Medic Examin	cal	LILLIAN 4a. Facility Name (If not institution, give	B. PARROTT		4b. City, Town, or		APRIL ath	1 Day 4c.	2005 ^{Year}	11:50 A
Funeral Director		Social Security Number 6. Se	alth Care x 7. Age (In yrs. D M 2 🛣 82	last birthday) Yrs.	Ft. Was If Under 1 Year Months Days	shington If Under 24 H Hours Mi	rs. 8. Date of B	irth	Prince Ge 9. Birthp 922 Virg	eorge's place (State or Foreigntry) ginia
la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince 6		y, Town or Lo	cation ashington	1			1	10d. Inside City Limi 1☑Yes 2☐N
23a or 28	al Director	10e. Street and Number 12121 Livingston	Road		10f. Zip Code 207 6	44			zen of What Coul	ntry?
point. Tages I and 2.3 strong being maintening to the strong strong sector from many and Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other treumstic event, the Medical Eventher must be notified at once.	ted by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Edit		16a. Deced	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No Ient's Usual Occupa	Specify:	erto Rican, etc.)		14. Race - Americ Black, White, Specify: B1 and of Business/In	etc. ack
glene. erthen "n . tre Med	Completed	(Specify only highest grade Elementary/Secondary (0-12) 6th	College (1-4or 5+)	life. I	kind of work done of DO NOT use retired stic	turing most of w	orking		Private	
Mental Hy arked oth atic event	To Be (17. Father's Name (First, Middle, Last) Albert Green				18. Mother's N	ame (First, Middle George	e, Maiden	Sumame)	
alth and 27 is me		19a. Informant's Name/Relationship (7) Tyrone Parrot			Abbotts					
Department of His Department of His Importent: If iter any injury or oth		20a. Method of Disposition 1 Daurial 2 Cremation 3 1 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	Removal from State Res	surrect	sition (Name of natory or other place ion Ceme: Name and Address T4 Lando	tery 4/	. B. Jen	Clir kins		yland Home
Medical xaminer the private th	dlcal Examiner	23a. Part1. Enter the disease, or comp shock, or heart faiture. List only commediate Cause (Firfal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that caused the deat one cause on each line. Myocardial a	Infarouence of): rosis (ction			arrest,		Approximate Interval Between Onset and Death
the attending hed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			2	23d. Date of delive Month	ery Day Year
s been sign 2 should be	Completed by Ph	Part II. Other significant conditions co		ulting in the u	nderlying cause give	en in Part I.	1 🗆	Yes 2	No 3 Prob	ne cause of death? pably
ate	e Com	25. Was case referred to medical				Of Place of D	auto perf	ormed? 2 K No	death?	_
h, After this funeral di	ToB	avaminar?	Hospital: 1 Inpatient 2 Inpat	ER/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 █ Nursing	Home 5 Res	idence 6		y)
within 24 hours after death. To the Funeral Director: After completely filled in by the fune	l Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	y) 			City or To	wn, State)		
within 24 hours a To the Funeral C completely filled	ledical	(Check only 2 Medicel Exem	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my op	oinion, death oc	ce, and due to the curred at the time	, date and	place, and due to	tated. the cause(s)
Som Con	Σ	29b. Signature and title of certifier	0		29c. License	number		29d. Date	e signed (Month,	

State of Maryland / Department of Health and Mental Hygienen 3304 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Franklin Parsons Perdue 8:00 pM March 31, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1529 Woodland Road Salisbury Wicomico 8. Date of Birth (Month, Day, Ye 5/9/1920 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1XM 2□F Director 214-32-6411 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1⊈Yes 2 No Maryland Wicomico Director Salisbury 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1529 Woodland Road 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛱 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Perdue Farms 12 Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur W. Perdue Pearl Lettie Parsons 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitzi A. Perdue/wife 1529 Woodland Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery_crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jerusalem Church 4/6/2005 Parsonsburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funer I Service Liceuse 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 ren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** respiration disease or condition resulting in death) /Medical s a consequence f): Due to (o **Examiner** Parkillsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Cause (Discase or injurthat initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Pyes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No death. investigation ☐ Accident after death Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within ? To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21953 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who MD, 31149 Roger Wenni 06 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2005 Registrar

			For State Registrar	State of Ma	ryland / l	Department of I Certificate of			2005	13305
			Decedent's Name (First, Middle, Last	nt)				2. Date of Death		3. Time of Death
	Physicia /Medic		Bertha Lil	lian 1	Pruitt			Mgnth 04	Day Ye 05	9ar 08:16 ^{AM}
	Examin		4a. Facility Name (If not institution, give	/	l Cen		or Location of Death		4c. County of D	
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last bii		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9.	Birthplace (State or Foreign Country)
	Director		215-26-5596	OM 200 74		Yrs.	1.1000	7/2/1930	1	aryland
	and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location				10d. Inside City Limits
	Mary -f sh	tor	Maryland Wicomi	co	Sali	sbury				1 ☐ Yes 2 XNo
	h the	lrec	10e. Street and Number			10f. Zip Code		100	. Citizen of Wha	t Country?
	th wit	Funeral Director	32379 Johnson Ro	l .		2180)4		USA	
	r dea	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe lan, Mexican, Puerto f	cify Yes or No- Rican, etc.)		American Indian, White, etc.
36	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f show than "netural Examinet" is the rutilied at	by Fi	1 ☐ Never Married 252 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:)	1 ☐ Yes 2 ☑ No	Specify:		Specify:	white
21215-0036	tural	edk	15. Decedent's Ed	lucation	16a	. Decedent's Usual Occur	pation	16	Sb. Kind of Busine	ess/Industry
212	nin 72 in ne	Completed	(Specify only highest gra	de completed) College (1-4or 5+		(Give kind of work done life. DO NOT use retire	during most of working	ng		,
21	ad wit	Com	11	_		immer/inspe	7		Shirt Fa	ctory
pu	be filk tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
$\frac{2}{3}$	ould Men Marke	T _o	Louder Washingto	<u> </u>	101	Marillan Addison (Chan	Bertha Li			7- O- d-1
Maryland	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Items 23a or 28a-f show any migry or other treumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Robert Lee Pruitt			D. Mailing Address (Street				
	1 an Heall tem 2		20a. Method of Disposition	SI/IIusbaik	20b. Place o	32379 Johnson Disposition (Name of	. D		oc. Location - City	
Baltimore,	Pages ent of nt: if if		1 🔀 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify		Sprin	ry, crematory or other pla ghill Memory		2005	Hebron,	MD
틅	mit. F		21. Signature of Funeral Service Licer		Ga	rdens 22. Name and Addre	ass of Facility		•	
ä	Dep Imp		Harris H.	Domoon	CFS	P 501 Snow	Funeral Ho Hill Rd.,	me Profe Salisbur	essional v. MD 2	Association
	1 777		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused tone cause on each line	he death. Do					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cere	howe	scular acci	dont			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):				3 00-10
	LAMINICI	ē	Sequentially list conditions,	b. Due to (or as a	consequence	Sillation .				uncate
	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	ory.				
<u> </u>	execunand nand ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a	consequence	of):				
38760,	cate be executed physician and the burial-transit	dlcall		d						
9		a)	IF FEMALE:						1	
Box	iaw requires that the death certifics as been signed by the attending pl 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of 1 ☐ Live birth 2			:y		23d. Date of Month	f delivery Day Year
Ö.	ne dea the ai	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me of death	5 Other (specify)				
P.O.	res that the de signed by the a I be detached f		Part II. Other significant conditions of	ontributing to death but	not resulting	in the underlying cause gr	ven in Part I.	23e. Did toba	cco use contribut	te to the cause of death?
Records,	uires sign	d by	Ho prior	cerebovasce	uler a	ceident		1 ☐ Yes	2 No 3	Probably 4 Unknown
CO	w require been signal	lete						24a. Was an	24b. Were	e autopsy findings available
Re	The lav	Completed						autopsy performe	d2 deat	
Vital	eician:] certifica irector, p	0	25. Was case referred to medical				26. Place of Death		2110	163 20110
\	S 00 0	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien	t 2 = ER/O	utpatient 3 DOA	her: 4 \(\text{Nursing Hom}	ne 5 Residen	ce 6 □Other (S	Specify)
n of	ding Phy h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of 28c. Inju Injury Wo		8d. Describe how	injury occurred	
sio	Attending r death. sctor: After	cati	2 Accident investigation 3 Suicide 6 Could not b	9			Yes 2 No	096 Lanatina (Ctua	-4	2
Division	or Al after c Direc in by	Certification:	4 Homicide determined	building, etc.		arm, street, factory, office	-	City or Town,		or Rural Route Number,
_	• Hospital or Attend 24 hours after death • Funerel Director: etely filled in by the	al C	29a. Certifier 1 Certifying Ph	vsician: To the best of	my knowledg	e, death occurred at the t	ime, date and place, a	and due to the cau	se(s) and manne	er as stated.
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examone)	niner: On the basis of a	examination ar	nd/or investigation, in my	opinion, death occurre	ed at the time, date	and place, and	due to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier			29c. Licen	se number	290	I. Date signed (M	fonth, Day, Year)
)	63		> Styph (4			D	41721		04,05,	05
	E.		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Print)				
	1/3		STEPHAN PAVEDS			bre or 5	ALISBURY Y	mp 2180)4	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 2	005 Sz. Agistrar	's Signature	Spark				
	3.0.			-	J.J.	MUNICIPALITY				

215-24-5586

Berthal Pruit

			1 - For State Registrar	State of	Marylar		artmen rtificate				ental Hy	gienje (Rog. No.	005	133	06
	Dhuaiai		1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3. Time of	Death
	Physici /Medio		Ruth Sparks	Pru	itt						March	31	2005	2:57	P M
	Examin	er	4a. Facility Name (If not institution, give		nber)				Location of	of Death			ounty of Deeth		
			Rockville Nursi		7 1 - 11	In a bit trade at a like		ckvi]		24 Hrs	0. Data -4 Dis		1ontgom		
Ы	Funeral		5. Social Security Number 6. Se 239-07-6042	x]M 2∭F	7. Age (<i>In yr</i> s. 89	, rast birthoay) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	n y, Year)		place (State o	
N	Director		Usual Residence of Decedent								Jan. 24	, 191	6 Nort	n Caro	lina
	yland		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside Cit	
	Mar.	혅	Maryland Montgom	ery]	Potomac	2							1 🗌 Yes	2 No
	or 28	ire	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	intry?	
	ous after death with the Manylar ral', or items 23a or 28a-f show Extrainer transt be rediffed at	ai	13009 N. Commons	Way				2085	4			Uni	ted Sta	ates	
	r dea	ne	11. Marital Status	12. Was Dece Armed For	ces?	J.S. 13.	Was Deced	dent of Hi	ispanic Ori n, Mexicar	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)	- 14	 Race - Amer Black, White 		
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married : 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv	е		1 ☐ Yes	2 🔯 No	Specify:			S	Specify: Whi	. + 0	
9	72 hours after death with the Maryland natural', or liems 23a or 28a-f show disal Examinetroual be indiffed at	Pa Da	15. Decedent's Edi	Year or Da		16a. Dece	dent's Heus	al Occupa	ation			16h Kind	of Business/li		
15	in 72 n "na	piet	(Specify only highest grad	le completed)		(Give	kind of wor	rk done a	during mos	t of workir	ng	TOD. TUITO	3 01 003111033211	iloustry	
21215-0036	d within giene. r than "	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1	- 4 0r 5+)	Home	emakei	r				Owr	n Home		
Б	be filed ital Hygie of other	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden S	umame)		
<u>la</u>	should b nd Ments marked umatic e	To E	Blaine L. Spark	S					I1	a Ho	lbrook				
Maryland	nit. Pages 1 and 2 should be filed within artificial of Health and Mental Hygiene. ortainst if Item 27 is marked other then injury or other treumatic event, Ins. 8.		19a. Informant's Name/Relationship (T								i Route Numbe				
	and ealth m 27		Judy Pruitt Flax	/ Daug					ons W		Potomac				
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ I	Removal from S	_	Place of Dispo cemetery, crer	natory or o	ne of ther place	e) [April	3,		ation - City or T		
Ħ	tmen tant:		*4 □Donation 5 □ Other (Specify,		Tr	aphill			_	2005		_	hill, N	1.C.	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after dea Obepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or items any injury or other treumatic event, Item and item in the montal Extra direction.		21. Signatuke of Funeral Service Licens	100	~						ol Fund			20877	
			23a. Part1. Enter the disease, or comp	lications that ca	sused the dea						Gaithe		.rg, MD	Approximate	9
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on e	ach line.	1,		1.		1	1			Interval Bety Onset and D	
	Physician /Medical		disease or condition resulting in death)	a	MDSC/10	erotic	car	~a101	Vasci	uar	disea	1SC_			
	Examiner	1		Hung	erten	SION									
山寨		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):				-					
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c											
30,	oe exe		resulting in death, Last	Due to (or as a consec	quence of):									
8760,	physic the t	Physician/Medical	•	d											
9 X	that the death certific ed by the attending p detached for use as t	/Me	IF FEMALE:	23c. If yes, out	come of prean	ancv						22	d. Date of deliv	(80)	
Box	atter atter for u	cian	in the past 12 months?	1 Live b	irth 2 ☐ Feta ant at time of c	al death 3□	Ectopic pr Other (sp					23	Month	*	'ear
o.	the d y the ached	iysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unkno											
Θ,	res that igned b be deta		Part II. Other significant conditions co	ntributing to de	ath but not res	sulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco use	e contribute to	the cause of d	eath?
Records,	w require been sig should b	Completed by	Anemia								1 🗆 Y	'es 2 🔀	No 3□Pro	bably 4 □U	nknown
ဝွ	aw requisite the second state of the second	piet									24a. Was		24b. Were aut	opsy findings a	vailable
	The I	E									autop perfo 1 Yes	rmed? 2 X No	death?	ompletion of ca	1050 01
ita		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			-5/	
of Vital	Physician: The lav this certificate has ral director, page 2	10	1 Yes 2 No	Hospital: 1 🔲 li	npatient 2	ER/Outpatier	nt 3□ DO	Othe	9r: 4 Nu	ırsing Hon	ne 5 🗆 Resid	ience 6	□Other (Spec	ify)	
D C	ding Pl h. After tl funera		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of (Monte	of Injury h, Day Year)	28b. Time of Injury	2	8c. Injury Work			28d. Describe h	ow injury	occurred		
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 🗌						
Division	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory	r, office		2	28f. Location (S City or Tox	itreet and i m, State)	Number or Hui	al Houte Numi	ber,
_	pitel ours a merel l		29a. Certifier 1 Certifying Phy	rsicien: To the	best of my kn	owiedne deat	h occurred	at the tim	ne date an	nd place, a	and due to the	rause(s) a	nd manner as	stated	
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Exam	iner: On the ba	asis of examina	ation and/or in	vestigation,	, in my op	pinion, dea	th occurre	ed at the time,	date and p	lace, and due	to the cause(s)	
	ro th within Fo th	Me	29b. Signature and title of certifier		1 11	,	290	. License	e number			29d. Date	signed (Month	Day, Year)	
•			Patricia 16	make	to Ma	ty, Mi	20	DS	5191	6'		Mar	ch 3	1, 200	5
	5		30. Name and address of person who c	ompleted caus	e of death (Ite	m 23a) (Type,	Print)	n.1		10-	n /	. []	1	4-	
			Patricia Tomsko	Nay,	11119	Kock V.	11/10	PiKE	e, 6	-1003	Kock	VIIIE,	MD 2	1085L	/
	Sta Registr		31. Date filed (Month, Day, Year)	05 AZ R	egistrar's Sign	ature	esta)					/			

William Correll Rollins

			1 - For State Registrar	State of Marytar		tificate of			Reg. No.		000.
	Physici /Medio		1. Decedent's Name (First, Middle, Las William C.	Rollins				2. Date of Do	3 Day	2009	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give Doctors Hospita			4b. City, Town, o	r Location of Death	/		ounty of Death nce Ge	eorges
	Funeral Director		5. Social Security Number 231-14-8984 6. S			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D		9. Birthp.	lace (State or Foreign
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Prince		ty, Town or Lo	cation				11	0d. Inside City Limits 1 ☐ Yes ※ No
	th with th	Funeral Director	10e. Street and Number 533 Pacer Driv	<i>r</i> e		10f. Zip Code 20785			10g. Citizer	of What Coun	try?
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23e or 28e-f show or other treumatic event, the Medical Exeminar must be mailtied at		11. Marital Stat <i>us</i> 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, Decify: B1a	etc.
Maryland 21215-0036	d within 72 h giene. sr then "natu The Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 8th		(Give	dent's Usual Occup kind of work done DO NOT use retired SCaper	ation during most of work 1)	king		of Business/Inc	Service
land	2 should be filed withing and Mental Hygiene. Is marked other there eumatic event, the Mental the M	To Be C	17. Father's Name (First, Middle, Last) William Rolli				18. Mother's Nam		e, Maiden Su	imame)	_
	ss 1 and 2 sho of Health and b Item 27 is ma r other treuma		19a. Informant's Name/Relationship (Frances Jeter	,sister	533	ng Address (Street Pacer D			Md. 2	20785	
Baltimore,	t, Pa rtmer rtent:		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	_{cemetery, crer} ne1ten	sition (Name of natory or other place ham Cem	3/7	/2005	Chel	tion - City or To tenham	, Md.
Bal	Departing Important rany reports		21. Signature of Funeral Service Licer	m M01325	P	O Box					cal Home
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea	th. Do not ent			or respiratory a	arrest,		Approximate Interval Between Onset and Death IZ days
0,	icate be executed by physician and sthe burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect	mi 🔑					/4	7 days
68760,	rtificate be ng physici s as the bu	Medicai		d					· · · · · ·		
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oags 2 should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 0 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)	'		230	d. Date of delive Month	Day Year
rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions of Atherosclero	ontributing to death but not re-					tobacco use Yes 2	_	e cause of death? ably 4 Unknown
of Vital Records,		Completed						24a. Was auto per 1 Yes		prior to cor death?	psy findings available inpletion of cause of
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea				
on of	Phys this ral dii	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur	4 🗆 Nursing H	ome 5 Res 28d. Describe			/)
Division	of or Attender is after death	Certification:	3 Suicide 6 Could not be determined		nome, farm, str ify)	reet, factory, office		28f. Location City or To	(Street and Nown, State)	lumber or Rura	l Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medicai C		nysicien: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time	, date and pla	ace, and due to	the cause(s)
)	To the within To the Comp	×	29b. Signature and title of certifier	luna		29c. Licens	e number		29d. Date s	igned (Month,	Oay, Year)
4	Bbil		30. Name and address of person who Peter M Schis.		m 23a) (Type,	Print)	Gr Dr.	Green	belt, i	40 20	770
	Sta Regista		31. Date filed (Month, Day, Year) APR 0 6	2005 32. Registrar's Sign	ature A	follo					

			ricas	•			artment of			•		_		
			1 - For State Registrar	State of	iviai yiai	•	rtificate			ieniai ny	Reg. No.	005	13308	
			Decedent's Name (First, Middle,	Last)						2. Date of De		Vans	3. Time of Death	_
	Physici /Medic		Lizzetta Logan	Rhudy						April	1	2005	10:22 P M	
	Examin	er	4a. Facility Name (If not institution,					n, or Location	of Death			County of Dea	th	
	Eunaval		Union Hospital 5. Social Security Number		. Age (In yrs.	last birthday)	Elkton If Under 1 Ye			8. Date of Bi	rth.	cil 9. Bir	thplace (State or Foreign	_
	Funeral Director		214 20 1595	1 □ M 2/EXF	8:	1 Yrs.	Months Da	ys Hours	Min.	Jan. 2	ay, Year) •1924	C	yland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits	
	Manyli f sho	ţō	Maryland Cecil			th Eas							1 ☐ Yes 2X No	
	h the	Director	10e. Street and Number		NOL	сп ваз	10f. Zip Cod	le			10g. Citi	zen of What C	ountry?	_
	ath wil	raiD	2650 Pulaski Hig				21901					ed Sta		_
	itams	Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie	12. Was Deced	eş?	.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Ori Suban, Mexicar	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whi		
036	urs aft	þ	3 ☐ Widowed 4 ☐ Divorced	lf Yes 2 If Yes, Give Year or Dat			1□Yes 2🛛	No Specify:				Specify: Wh	ite	
Maryland 21215-0036	ba filed within 72 hours after death with the Maryland lat Hygiene. id other than *natural; or itams 23a or 28a-f show event. The Modical Excitution is used by multiple at	Completed	15. Decedent's (Specify only highest	Education grade completed)	· · · · · · · · · · · · · · · · · · ·	(Give	dent's Usual Oc	<i>ne durina</i> mos	t of worki	ng		nd of Business		
7	within ne. han	mpl	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	DO NOT use re	tired)						
ر م	filed v Hygie other t	CO	12 17. Father's Name (First, Middle, L	2ast)		Secre	tary	18. Mothe	er's Name	(First, Middle		ication Sumame)		
lan	fental rkad c	To Be	William J. Logan					Marth	na B.	Goodn	o₩			
ary	and N ls mai		19a. Informant's Name/Relationshi			19b. Maili	ng Address (Str	eet and Numbe	er or Rura	al Route Numb	ber, City o	Town, State,	Zip Code)	
	permit. Pagas 1 and 2 should ba filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other traumatic event, the Modical Examinations ust be notified at ODGs.		George Rhudy/Hus 20a. Method of Disposition	band	20h E		Pulask					(arylan		
Baltimore,	agas nt of h t: If ite		1 Burial 2 □ Cremation : 4 □ Donation 5 □ Other (Sp.		tate No	rth Ea	osition (Name of matory or other st Metho etery	odist A	pril	_5,				
틆	artme ortani injury		21. Signature of Four all Service				etery 2. Name and Ad					h East	Maryland	
ä	Departiment of the particular in the particular		Julio El Cro	1		1:	27 Soutl	h Main					yland 21901	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that can	used the deat ch line.	h. Do not en	ter the mode of	dying, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)				NFARCT	w					Hours	
1	/Medical Examiner		resulting in death)		ras a conseq		rice Nic						YEARS	
	-7.0	ler	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury		r as a conseq		fay Dis	EASK.						
9	cutad nd ransit	Examiner	that initiated events	V	PENTE								TRACI	
760,	icate be executad physician and s the burial-transit		resulting in death) Last	Due to (o	r as a conseq	quence of):								
687	physicate Is the k	dicai		d									-	-
Box (n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			75-41				2	3d. Date of de	livery	
O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No		th 2. ☐ Feta nt at time of c vn		∃Ectopic pregna ∃ Other (specify					Month	Day Year	
P. 0.	hat the	Phy	9 Unknown Part II. Other significant condition	s contributing to dea	ith but not res	ulting in the u	ınderivina cause	given in Part I	l.	23e. Did	tobacco u	se contribute t	o the cause of death?	
of Vital Records,	uires tha signed ild be dei	d by	Cerebrovas					3		1 🗆	Yes 2[3No 3□P	robably 4 DUnknown	
CO	aw require s been si z should I	Completed	Now Insuli	4 Depend	id to	wheter	Mellita	~1		24a. Was		24b. Were a	utopsy findings available completion of cause of	
E E	The lav	mo								auto perf	ormed?	death?		
/ita	Physicien: Th rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hospital:						(Check only				_
of	Physi rthis c ral dir	. To	1 Yes 2 No	28a. Date of	patient 2 🗷	ER/Outpatie		njury at		me 5□Res 28d. Describe		Other (Spe	ecify)	-
on	nding tth. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	, Day Year)	Injury		Work? 1 □ Yes 2 □						
Division	l or Atte after dez Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Place	of Injury - At h g, etc. (Specia	ome, farm, st	reet, factory, off	ice			(Street and		ural Route Number,	
	urs aff								<u> </u>					_
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying (Check only 2 Medical E	p Physician: To the b examiner: On the bas and manne	sis of examina	ation and/or in	n occurred at the expension, in n	e time, date ar ny opinion, dea	ath occurr	ed at the time	, date and	place, and du	s stated. e to the cause(s)	
	To the within To the Compl	Me	29b. Signature and title of certifier				29c. Lic	ense number				e signed (Mon		_
			> 4 MD				Do	04771	l		Apr	11 6,8	1005	
	10		30. Name and address of person v	no completed cause	of death (Iter	п 23а) (Туре,	Print)	3 EL	KTOW	MARFI	-A-V 11	2/4/31		
	Sta	ate	DANN GAN-EL 3 31. Date filed (Month, Day, Year) APR 6	32 Re	gistrar's Signa	ature				, .,,,		- , , , - (-
	Regist		APR 6	2005	was de	7 Agos	141							

			For State Registrer		State of M	arylan		artment rtificate			and M	ental Hy	gieni Reg. No	-000	13309
		d)	1. Decedent's Name (First,	Middle, Las	")							2. Date of De Month	eath Da	ay Year	3. Time of Death
, a	Physicia /Medic		Aline Josep	hine 1	Rivoal _							March		,	8:40 A M
	Examin		4a. Facility Name (If not ins	titution, give	street and number	r)		4b. City, T	own, or l	Location o	of Death		40	. County of Dea	th
1		ш	5401 Tuscara	was R	oad			Beth						Montgome	
	Funeral		5. Social Security Number	6. Se	x 7. A		last birthday)	If Under 1 Months	Days Days	If Under: Hours	Min.	8. Date of Bi (Month, D	ay, Year,	9. Bir Co	thplace (State or Foreign ountry)
	Director		579-56-3363		W 210	83	Yrs.					12/17	192	1 Fra	ince
	and	-	Usual Residence of Deced			10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	danyl f sho	ō	MD Mor	tgome	rsz	Ret	hesda								1 ☐ Yes 2 🙀 No
	28a-	ect	10e. Street and Number	egome	Ly	ВСС	nesda	10f. Zip (Code				10g. Ci	itizen of What Co	ountry?
	with 3a or	Ö	5401 Tuscara	TAGE D	and			208	16				F.	rance	
	ns 2:	Funeral Director	11. Marital Status	was K	12. Was Deceder	t Ever in U	.S. 13.			panic Ori	gin? (Spe	ecify Yes or N Rican, etc.)		14. Race - Ame	
(0	or Itan		1 Never Married 25	Married	Armed Forces						i, Puerto	Hican, etc.)		Black, Whit	te, etc.
g	ral', c	by	3 Widowed 4 Div	vorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2	NO LA	Specify:				Specify: Wh	nite
21215-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show Jical Evacinet must be notified at	Completed		cedent's Ed	ucation de completed)		16a. Dece	dent's Usual kind of work DO NOT use	l Occupat k done du	tion uring mos	t of worki	ng	16b. F	Kind of Business	/Industry
7	ithin	nple	Elementary/Secondary (College (1-4o	r 5+)								77 -	
	ed w ygien yer th	Co	12				Home	emaker		40 11-11-1		(F) 1 1 4 1 4 1 1	1 -	n Home	
pu	be fill tal H d oth	Be	17. Father's Name (First, M	fiddle, Last)								(First, Middle			
<u>y</u>	should be find Mental His marked of	2	Eugene Bossa				Eilin c					ine Che			7. 6.4.
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene it the fire at 1 stranged other than "natural", or Itams 23a or 28a-f show itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, Ital Peulos.		19a. Informant's Name/Re										-	or Town, State,	
d)	l and lealth im 27 har t		Dorinne Rivo	al, D	augnter	20h F	/832 Place of Dispo			ar L		Alexai		a, VA 22 Location - City or	
Baltimore,	First H		20a. Method of Disposition 1 ☐ Burial 2 X Crem	ation 3 🗆	Removal from Stat	e 0	cemetery, cre	matory`or oti	her place					•	
Ë	permit. Pages 1 Department of H Important: If its any injury or of once.		`4 □ Donation 5 □ O			Ft.									Maryland
3a	ermit bepar npor ny in		21. Signatore of Funeral S	ervice Licen	500	1		2. Name and				imple :			1 4 20052
	0 □ = 4 OI		1 Julle	yxle	anli	uh.				_				ie, mary	yland 20852 Approximate
			23a. Part1. Enter the diser shock, or heart failure	List only	one cause on each	line.	rui. Do not en	ter the mode	or dying	, such as	cardiac	r respiratory	arrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	a Sarcon	na									
	/Medical Examiner		resulting in death)		Due to (or a	as a conseq	quence of):								
	LAGIIIIIO	<u>.</u>	Sequentially list conditions		b. Due to (or a	s a conseo	uence of):								
	led isit	Examiner	if any, leading to immediat cause. Enter Underlying Cause Unisease of injury that initiated events	ື -{	200 to (0, 2	20 2 00.1009	1001100 017.								
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last		c Due to (or a	as a conseq	quence of):								
8760,	ate be ex nysician he burial	icalE													
687		edic			d			_							
×	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregn	201	23c. If yes, outcom	ne of pregna	ancy							23d. Date of de	elivery
Вох	atter for u	Physician/M	in the past 12 months		1 ☐ Live birth 4 ☐ Pregnant			□Ectopic pre □ Other (spe						Month	Day Year
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Δ.	requires that the een signed by th nould be detache		Part II. Other significant c	onditions o	ontributing to death	but not res	sulting in the t	anderlying ca	ause give	n in Part I		23e. Did	tobacco	use contribute t	to the cause of death?
ds.	uires n sign	d by										1□	Yes 2	2 □ No 3 □ P	robably 4 X Unknown
ecords,	≥ Q 5	ompleted										24a. Wa	s an	24b. Were a	utopsy findings available
	o - o	m'										рег	opsy formed?	death?	completion of cause of
Vital	ician: Th certificate rector, pag	ပိ	25. Was case referred to r	nedical						26 Place	of Death	1 Yes		0 1 1 1 1 1 1	\$ 21140
S		o B	examiner? 1 ☐ Yes 2 ☒ No	ilo diout	Hospital: 1 Inpa	itient 2	ER/Outpatie	nt 3□ DO	A Othe			-		6 ☐Other (Spe	ecify)
of		-	27. Manner of Death		28a. Date of Ir	njury	28b. Time o		8c. Injury Work			28d. Describe			.,,,
on	ft A j	it lo		Pending investigation		Jay Year)	Injury	м		' 'es 2 □	No				
Division	Attanding or death. actor: After by the fune	ifica		Could not be determined	286. Place of		iome, farm, si	treet, factory	, office			28f. Location City or To			Rural Route Number,
Ö	al or	Certification:	4 Homicide		building,	etc. (Speci	(y)					Only or 1	own, ora	10)	
	e Hospital or Attan 24 hours after deat a Funaral Diractor: etely filled in by the				ysician: To the be										
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 M	edical Exen	niner: On the basis and manner		ation and/or it	ivestigation,	ил ту ор	anion, dea	TILL OCCUL	eu at trie time	, uate ar	iu piace, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of	certifier	4	110	M	29c	License	number			29d. D	ate signed (Mon	th, Day, Year)
	0			170	1000	/ll	HUSS	lan I	D0060	0050			Mar	ch 31, 2	2005
	8		30. Name and address of	person who	completed cause of	f death (Ite	m 23a) (Type	. Print)							
			M. Hussain,	MD, 1					11e,	Mar	ylan	d 2087	7		
	Sta	ate	31. Date filed (Month, Day	, Year)			ature A								
	Regist	rar	APR	0 4 4	JUS JOHN	W S	5 19								

			. For	State o	of Marylan	d / Depa	artmen	t of H	ealth a	ind M	ental Hy	giene	005		3310
			1 - State Registrar			Cei	rtificate	e of L	Death			Reg. No.	000		. 0010
Н	Physici	an	Decedent's Name (First, Middle								2. Date of De Month	Day	Yea	ar	3. Time of Death 8:00 AM
	/Medic	al	Annabelle Hic				4h City	Town or	Location o	f Doath	April	3	200 County of D		3.00 // MC
	Examin	er	14614 Cearfos		illoor)								•		a 1
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months	1 Year Days	If Under 2 Hours	Z4 Hrs. Min,	8. Date of Bird (Month, Da	h v Year)	vasnir 9.	Birthplac	n County ce (State or Foreign
	Director		219-14-8013	1 □ M 2 💢 F	79	Yrs.	MONTHS	Days	Hours	IVIII I,	July 2	192	25 Pe	nns	ylvania
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							100	d. Inside City Limits
	Maryl f sho	ō	Maryland Wash	ington		I I a a a a a a a	.								1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number	rigcon		Hagers	10f. Zip	Code		-		10g. Citi:	zen of What	Country	y?
	filed within 72 hours after death with the Maryland Hygliene. Ither than "natural", or Items 23a or 28a-f show ith, the Medical Examiner must be notified at	a D	14614 Cearfos	s Pike				217	40		J	Jnite	ed Sta	tes	
	tems	Funeral	11. Marital Status	Armed F		.S. 13.	Was Deced If Yes, spec	lent of Hi ofy Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	.	14. Race - A Black, W		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3X Widowed 4 ☐ Divorced	ied 1 ∐ Yes If Yes, G Year or £	2X∑No ive Dates:		1 □ Yes	No	Specify:				Specify: W	hite	3
21215-0036	2 hou	led t	15. Deceden	t's Education		16a. Dece	dent's Usua	I Occupa	ation			16b. Kir	nd of Busine	ss/Indu	stry
215	thin 7	Completed	(Specify only higher Elementary/Secondary (0-12)		1-4or 5+)	life.	kind of woi DO NOT us	se retired	iuring mosi)	or worki	ng				
	ygien ygien her th			()			Purch	asin			/Fine & Adiabate		craft	Mf	J•
and	l be fil ntal H ad otl	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	матаеп	Surname)		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Marical Examiner must be notified at ance.	7	Roscoe Herman H 19a. Informant's Name/Relations			19b. Mailii	na Address	(Street a	and Numbe	elen	Gould I Route Number	Byer	S Hic	ks e Zip C	code)
Z	nd 2 s lith an 27 is r trau		George Herman								erstown				
re,	s 1 ar of Hea itam otha		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of ther plac	e)		ate	20c. Lo	cation · City	or Tow	n, State
Ē	Page nent c ant: if ury or		1 ☐ Burial 2 ▼Cremation '4 ☐ Donation 5 ☐ Other (S	3 ∐Removal from pecify)	State	ithsbu			1	Apri	1 5 05	Smi	thsbu	rg M	Maryland
Baltimore,	permit. Departr Importa any inju		21. Si nature of Funeral Service	Licensee			2. Name an			DOU	glas A.				
_	<u>205</u>		Musion	1 4	ny								wn Ma		and 21742
			23a. Part1. Enter the disease, or shock, or head failure. List	only one cause on	each line.			e or cryin	g, such as	cardiac o	or respiratory a	rest,		- In	nterval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		ore	you	ru 4	ory	·a	rest	_		-	nimede até
	Examiner			Due to	(or as a conseq	luence or):			U					-9	103
	- 8	je	Sequentially list conditions, any, reading to minimodate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	menda ot).								-	
	cuted nd transit	Examiner	that initiated events	с.	Hypen	Low	ساس	1							113.
,097	ate be executed nysician and he burial-transit	I Ex	resulting in death) Last	Due to	0 17	luence of):	-	, -							
687		dical		d		juice	Conc								
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ă.	death e atte	icia	in the past 12 months? 1 □ Yes 2 Ø No	4□Preg	birth 2 ☐ Feta nant at time of d		□Ectopic pr □ Other <i>(sp</i>						Month	D	ay Year
P.O.	at the by th	hys	9 Unknown	9⊡ Unki											
Ś	signed to det		Part II, Other significant conditi	ons contributing to	death but not res	sulting in the u	inderlying c	ause give	an in Part I.						cause of death?
ord	w requir been si should	eted									11				
Record	e la has	Completed									24a. Was autoj			to comp	sy findings available pletion of cause of
a		e Co	25. Was case referred to medica						OF Place	of Doath	1 Yes	2 🔼 No	10	Yes 2	□ No
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٦of	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date (Mo	of Injury oth, Day Year)	28b. Time o	of 2	8c. Injun			28d. Describe				
Sior	Attending r death. ector: After by the fune	atic	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation			М		Yes 2□	-					
Division	l or Attendatter death Director: In by the	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 288. Plac	e of Injury - At hading, etc. (Special		reet, factory	y, office			28f. Location (City or To			r Rural F	Route Number,
	Hospital	S	29a. Certifier 1 Certifyi	ng Physicien: To th	ne hest of my kar	nwledge deal	h occurred	at the tin	ne date an	d place.	and due to the	cause(s)	and manne	r as stat	ted.
	To tha Hospital or Atten within 24 hours after deat To the Funaral Director: completely filled in by the	edical	(Check only 2 Medical one)	Exeminer: On the and ma	basis of examina	ation and/or in	vestigation	, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and	due to th	he cause(s)
	To tha I within 2. To the I complet	Me	29b. Signature and title of certifie	r /			290	. Licens	e number			29d. Dat	e signed (M	lonth, Da	ay, Year)
			muser	18. C	In			13/	4800)			1/6/	03	
	H-10		30. Name and address of person MASSOUD B.	who completed can	use of death (Iter	m 23a) (Type,	Print)	erles	ich	57	Hager	5/0	uns	MD	ay, Year)
W)		ate	31. Date filed (Month, Day, Year,	32.	Registrar's Signa	ature	1 .				0				
	Regist		APR 0	6 2005	Mesen	B. F.	perse	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie [] ForAmend Item #17 State of Mary State Registrar WCHD/SH 4/6/05 per FH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Benous Bengle Cecnic 1600 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Washington Co. Hagerstown 17931 Garden View Road, Apt. B If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours 65 Director Pennsylvania 189-30-8231 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28e-f show ral', or Itama 23a or 28e-f shov Examiner must be notified at 1 Yes 2 No Washington Hagerstown Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ₿ 21740 View Road, Apt. 17931 Garden Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. e filed within 72 hours after call Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White XXWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic evant, the Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+Career Military US Goverment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental b Ronald V. Renouf Roland V. Renouf Letha A. McKnight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $17927Garden\ View\ Road$, Hagerstown, MD 21740 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is m any injury or other traum 2005. Kim Goulette (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 MRemoval from State
4 ☐ Donation 5 ☐ Other (Specify) 4/7/2005 Sandy Lake, PA Oak Hill Cemetery 21. Signature of Funeral Service Licensee Paul T. Lochstampfor 22. Name and Address of Facility Lochstampfor Funeral Home, Inc. Lochstampfor Funeral Home, Inc. 48 S. Church Street, Waynesboro, Lochstampfor Funeral Home, 48 S. Church Street, Waynest 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 48 S. Church Street, Waynesboro, PA Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Roterio Achertic Cardio Un carluz disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -Due to (or as/a consequence of): Examiner icheter Wellifu - the I attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical d. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 46 Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Besidence 6 Other (Specify) 2 🗌 No ٩ 1 Yes this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TYV e and address of person who completed cause of death (Item 23a) (Type, Print)

SH-10+1

DHMH 17 Rev 1/2001

State Registrar

		•	_ FOI	partment of Health and Menta ertificate of Death	Hygiene 005 13312
			Decedent's Name (First, Middle, Last)		te of Death onth Day Year 3. Time of Death
	Physicia /Medic		James Smith		- 29 - 2005 11:40 p M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Takoma Park	Montgomery te of Birth 9. Birthplace (State or Foreign
	Funeral Director		5.77-16-7295 18 M 2 F 88 Yrs	Months Days Hours Min. (Me	te of Birth onth, Day, Year) 9. Birthplace (State or Foreign Country) Georgia
			Usual Residence of Decedent		20 1)10 deorgia
	how	_	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Ba-f s	cto	Maryland Montgomery Silver		M∑Yes 2⊡No
	vith th	Director	8712 Colesville Road #309	10f. Zip Code	10g. Citizen of What Country?
	s 23g	Funeral		20910 3. Was Decedent of Hispanic Origin? (Specify You	U.S.A. es or No- 14. Race - American Indian,
	fter d	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No	If Yes, specify Cuban, Mexican, Puerto Rican,	etc.) Black, White, etc.
9	ral', o	þ	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 □ No Specify:	Specify: Black
5-0	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or items 23a or 28a-f show ther than "natural", or items for trofficed at ant, the Medical Evant act must be trofficed at	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of working	16b. Kind of Business/Industry
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7	filed y Hygie ther t		17. Father's Name (First, Middle, Last)	ding Engineer 18. Mother's Name (First,	Gravel Middle, Maiden Sumame)
Maryland 21215-0036	should be nd Mental marked o	To Be	James Smith	Bertha Walke	er
ary	shou ind M s mar umat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or Rural Route	e Number, City or Town, State, Zip Code)
	and 2 saith a n 27 is er tra		John M. George/friend Rock	orest Avenue ville, Maryland, 2085(1
timore,	of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of Date rematory or other place)	20c. Location - City or Town, State
Ē	Pages tment of I tant: If it		`4 □Donation 5 □ Other (Specify) Glenwoo	d Cemetery 04-07-05	0
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: in item 27 is marked other than "natural", or items 23a or 28a-f show amount injury or other traumatic event, the Medical Erach are trained for redifficed at Once.		21. Signature of Funeral Service Licensee Wanda C. Bacon, CC 361	3447 14th St., N.W. Wa	Bacon Funeral Home, Inc. ash., D.C. 20010
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respi	ratory arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		2 Vous
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	Margin (Marini	2010-0-
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		
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9	entific Jing p	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		2012/1/15
Box	death certifica attending pl d for use as t	Physiclan/Me	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
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۳.	The law requires that the death certific is that been signed by the attending page 2 should be detached for use as	by Pl	Part II. Dther significant conditions contributing to death but not resulting in th	underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
ğ	w require been sig should b	led l			1 Yes 2 No 3 Probably 4 Unknown
Records,	has be ge 2 sh	Completed		24	4a. Was an autopsy available prior to completion of cause of
	The cate h	Con		10	performed? death? ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Che	
o	Phys r this ral dii	<u>۲</u>	T Tes 2 No 1 I I I I I I I I I I I I I I I I I I	ient 3 DOA 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify) escribe how injury occurred
on	ading th. : Afte s fune	tlor	27. Manner of Death 1 Chatural 5 Pending (Month, Day Year) 2 Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No	
Division of Vital	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		cation (Street and Number or Rural Route Number, ty or Town, State)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical Ce	29a. Certifier (Check only 20 Medical Examiner: On the basis of examination and/o		
	o the ithin 2 o the omplei	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	- 3 + 8		> (2) dinal Drown	260381	3/31/08
R	(10)		30. Name and address of person who completed cause of death (Item 23a) (Ty	De, Print)	10 la 2 1 1 20 n
	Sta		31. Date filed (Month, Day, Year) APR 0 5 2005	was a	w jank was sours
	Regist	rar	APR 0 5 2005		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 1 per dr., G857,07/27/06dbb Registrar Registrar Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** William 2005 1020 AM Snead Apr.l /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Maryland Medical Center NIA Bultimore University If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1**№**M 2□F Director 231-58-2761 Aug 29, 1944 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 →Yes 2 No Be Completed by Funeral Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 10218 Old Ocean City Blvd. 21811 U.S. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Menial Hygiene.
Int: If item 27 Is marked other than "naturel; or Items 23s int: If item 25 marked other than "naturel; or Items 23s into or other treumals event, the Medical Example at must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Wivorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William A. Snead, Sr. Gladys Badger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andrew Snead/brother 4416 Deep Grass Lane, Houston, DE 19954 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny injury or once. Crematory of 4/9/2005 De marva Delmar, DE 21. Sign ware of Fund at Service Lie Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstruction Physician Laryngeal Month /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Tillnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown syndrome 24b. Were autopsy findings available prior to completion of cause of death? peripheral 24a. Was an Vascular Diserce autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medicai Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: Aid in by the fu 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 2, 2005 1858 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Fenlel 22 S. Greene St., SKNEZETO, Bultimore, MD2120

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Raistrar's Signature

6 2005

OWNER/OPERATOR OWNER/OPERATOR OWNER/OPERATOR Is Member's Name (First, Medder, Masser Summan) 1. Member's Name (First, Medder, Masser Summan) DAVID CROCKETT STOCKTON Is Making Actres (Street and Number or Paul Route Number, or Town, State, 2D Code) SUZANDE DIFFANKS DAUGHTER 22 NORTH MAIN STREET, SELBYVILLE, DE. 19975 224 What And Summar of Summar of Town, State Contents of Chemistry of Summar of Commerce of Comme			4	For State Registrar		State o	f Marylan		partment of e <i>rtificate of</i>	Health and I <i>Death</i>		giene Reg. No.	005	13314
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Physician Phys		r dea	ner			12. Was Dec Armed Fo	edent Ever in U	l.S. 13	 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	o- 1		
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DAYLD CROCKETT STOCKTON NOMA LEDFORD DAVID CROCKETT STOCKTON NOMA LEDFORD 199. Mailing Address (Sineer and Number or Rural Route Number City or Town, State, Zip Code) SUZANNE DIFFRANKS/DAUGHTER 20. Method of Disposition 1	22	thin 7 e. en "n Medi	nple	Elementary/Secondary (I-4or 5+)				iniig	CPC	CEDV E	ን ድጥለ TT
DAVID CROCKETT STOCKTON NOMA LEDFORD 19a. Informant's Nama-Relationship (Type, Print) 19a. Informant's Nama-Relationship (Type, Print) 19b. Informant's Nama-Relationship (Type, Print) 20b. Place of Disposition 1	2	led wi lygien har th	Co		fiddle (ast)			OW	NER/OPERA	T	me (First Middle			EIALL
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Physician (Medical Examiner Medical Examiner				23a. Part1. Enter the diseashock, or heart failure	ase, or comp	plications that one cause on e	aused the dea	th. Do not	enter the mode of dy	ving, such as cardia	c or respiratory a	rrest,		Interval Between
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FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ó	e exectan an an arial-tr		resulting in death) Last	- 1	Due to	(or as a consec	quence of):						
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	876	cate by	dica		•	_ d								
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29a. Certifier (Check only one) 29b. Signature and title of certifier (Pack only one) 29b. Signature and title of certifier (State of the date) 29c. License number 29d. Date signed (Month, Day, Year) 32. Registrar's Signature State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		i Dir	ertif		determined				street, factory, offic	9			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
29b. Signature and title of centifier 29b. Signature and title of centifier 30. Name and address of person who completed cause of heath (Item 23a) (Type, Print) AND COUNTY WORTH CONTRACTOR OF Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hospits 4 hours Funaral tely fillec		(Check only 2 ☐ M	ertifying Ph ledical Exar	niner: On the b	asis of examin	owledge, de ation and/o	eath occurred at the rinvestigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
30. Name and address of person who completed cause of feath (Item 23a) (Type, Print) AND CHALL MM CASTAL HASPING: P.O. BX 1733 Solushin, MD 21807 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		o the ithin 2 o tha omplet	Med		certifier			1	29c. Lice	nse number		29d. Date	signed (Mon.	th, Day, Year)
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		tmf		30. Name and address of	person who	completed cau	se of eath (Ite	m 23a) (Ty	pe, Print)	Bx 1733	So	Tich ~	M	021802
Registrar APR 0 7 2005 Klesse St. Spark						2005	Redistrar's Sign	nature	South	V-(1)		1000	0	

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** April OI 2005 Flossie A. Smith 7:05 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manchester Carroll Long View Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ X 219-42-5394 Yrs. Director 90 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 17 is marked other then "natural", or itams 23a or 28a-f show traumatic event, the Madical Examinat must be notified at Westminster 1 Yes 2 No Director Carroll 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21157 3609 Sykesville Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental and Mental Della Arnold George Hershel Miller Pages 1 and 2 should I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19 Westmoreland Street Westminster, MD 21157 item 27 l Howard Smith, Jr/son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of i Important: If it any injury or o 1 Dauriai 2 Cremation 3 Removal from State 4/05/2005 Sykesville, MD Lake View Memorial Pk 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Prittsdoffineral Home and Chapel, P.A. ach 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Surara **Physician** disease or condition resulting in death) /Medical Examiner Lene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a fronsequence of Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 NODIN 1 🗌 Yes 2 No 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 戊 No 24a. Was an has autopsy performed? Yes 2. No 1 ☐ Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 TINO death. after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral C filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 51705 4-1-2005 afuma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster 349 PANSURIYA malcolm 31. Date filed (Month, Day, Year) 32. Recontrar's Signature State APR 0 4 2005 Registrar

Amended Item 19a per F.D. 04/05/2005 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 13316 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 0010 <u> April</u> 2005 Daniel Ross Stephens /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2015 Old Westminster Pike Finksburg Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□ F Months Hours Yrs. Director Sept 9, 1959 Maryland <u> 212-78-9179</u> Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location in then "natural", or Items 23e or 28e-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Finksburg Marvland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2015 Old Westminster Pike 21048 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 15 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Importent: If item 27 is marked other th eny injury or other traumatic event. III. System Planner BGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Barbara Hust Jack Stephens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) You member and the property Type, Print) 2015 Old Westminster Pike Mrs. Jintao Stephens wife Finksburg, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Sandy Mount Cemetery 4/4/2005 Finksburg, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service License 412 Washington Rd. Westminster, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ymphoma Pnysician VEGYS /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissas of Hijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): sician ar e burial-t P.O. Box 68760. phys. the b attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2**N**0 1 🗌 Yes 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 2 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 52477 e and address of person who completed cause of death (Item 23a) (Type, Print) Stpot, Berthman poport スス South 32. Regultrar's Signature 31. Date filed (Month, Day, Year) State APR 04 Glown & Speck Registrar

Amended Item 16a per F.D. 04/05/2005 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Frances Katherine Swim 2005 6:30 a 04 <u> April</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Carrol1 Carroll Hospital Center 8. Date of Birth (Month, Day, Y July 14 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2√2 F 87 Yrs 220-09-8234 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 423 High Earl's Road 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 StNo Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working **MquQSGTusomiss**) **Librarian** 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aguisitions Libriarian 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Rife Fox Carrie Unglaub 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 423 High Earl's Rd Westminster, MD Jasper A. Swim/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State iX Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Westminster Cemetery 4/07/2005 Westminster, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral well. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final Acute enkemic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Vone 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Hospital or Attending Physician: The law requires that the death certificate be executed P.0. Division of Vital Records,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Items 23a

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To the Funeral D
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Registrar

State

Medical

29a. Certifier

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

1 Acertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

St. Westminster ud.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 S. Canten

aicut 2 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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	Physici	an	1. Decedent's Name (First, Middle, Last,)					Date of Dea Month	ath Day	Year	3. Time of	
	/Medic		Mary M. Sullivan						April 1			2:35	a M
):	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location o	of Death		4c. Co	ounty of Death	1	
-N	,		National Luther				ville	24 Hrs	0. Data of Bird		ontgome		- F
	Funeral		5. Social Security Number 6. Security Number 1	M 2127 F	vrs. last birthday) Yrs.	Months Days		Min.	8. Date of Birtl (Month, Day			place (State of	
	Director		Usuel Residence of Decedent	3	31 '''				May 30,	1923	3 Rhoc	de Isla	ina
	land		10a. State 10b. County	100	. City, Town or Lo	ocation						10d. Inside C	ity Limits
	Man,	ţō	Maryland Montgo	merv	Rockvi	lle						1 XYes	2 🗆 No
	r 28e	Director	10e. Street and Number			10f. Zip Code				10g. Citizer	n of What Cou	intry?	
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	deat ms	by Funerai	11. Marital Status	12. Was Decedent Ever i	in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Orig	gin? (Spec	cify Yes or No-	14.	Race - Amer Black, White		
9	or ite	F	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give		1 ☐ Yes 24 ☐ No			,,		pecify: Whi		
ğ	within 72 hours atter death with the Maryland ene. than 'maturel', or items 23a or 28e-f show ta Modical Examinar mast be notified at	d b	3 Widowed 4 Divorced	Year or Dates:									
<u>v</u>	nat	iete	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	t of workin	g	16b. Kind	of Business/I	naustry	
2	withir ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ncipal	<i>5</i> 0 <i>7</i>			T27.0==	-	- Cabaa	. 1
2	Hygid Ther ant.	ပို	17. Father's Name (First, Middle, Last)	3+	PET	пстрат	18. Mothe	er's Name	(First, Middle,			Schoo	L
au	d be ental	To Be	John McArdle				Cat	heri	ne O'Ne	eil			
Maryland 21215-0036	Shoul nd Mi mari	-	19a. Informant's Name/Relationship (T)	γρe, Print)	19b. Maili	ng Address (Stree	t and Numbe	er or Rural	Route Numbe	er, City or To	own, State, Z	ip Code)	
Š	nd 2 alth a 27 le r treu		Edward T. Sulliva	n/Husband	9807	Veirs D	rive,	#3, I	Rockvil	le, M	Marylar	d 2085	0
ē,	item othe		20a. Method of Disposition		b. Place of Dispo	osition (Name of matory or other pla	ace)		ate 1 20	20c. Local	tion - City or 1	Town, State	
Ĕ	Page in the control of the control o		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)		Arlington	National C	emetery	200		Arlin	oton,	Virgin	ia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28e-1 show minjury or other treumatic event, the Medical Examiner rast is notified at once.		21. Signature of Funeral Service Licens	ee	f	2. Name and Addr	ess of Facilit	ins l	Funeral				
<u>m</u>	89 = 9		dans s	Doly	5	00 Unive	rsity	Blvd,	, W, Si	lver	Spring	, MD 2	0901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the one cause on each line.	death. Do not en	ter the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approximat Interval Bet Onset and	ween
Ľ	Pnysician		Immediate Cause (Final disease or condition	phei	emor	110						6 dA	
	/Medical Examiner		resulting in death)	De to (or as a cor	sequence of):								
	Examiner	L		b									
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687	ficate physis the			d									
	nding use a	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		75				230	d. Date of deli	very	
ň	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐ 4☐Pregnant at time		□Ectopic pregnan: □ Other <i>(specify)</i> _		·			Month	Day	Year
P.O. Box	Attending Physician: The law requires that the death certifica refeath. refeath. ector: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	by Physician/Med	9 🗆 Unknown	9□ Unknown									
	res tha igned be de	y P	Part II. Other significant conditions co		,	inderlying cause g	ven in Part I.					the cause of c	
ğ	w require been signature should b		412 heiner	S Dem	entia				101	res 2 St	No 3∐Pro	obably 4 □l	Jnknown
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ř	The ate his page	E O							perfo	rmed?	death? 1 ☐ Yes	2 🗆 No	
a	ian: artifica ctor.	Be (25. Was case referred to medical examiner?						Check onl o				
<u>></u>	hyeic his ce I dire	101	1 ☐ Yes 2 ∑(No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie				ne 5□Resid			efy)	
0	ng Pł fter tł mera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	W			8d. Describe h	now injury o	occurred		
20	lendii eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Tes 2□		26.1	2		10	-6
Division of Vital Records,	or Ati fter d Sirect in by	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (Sp		reet, factory, office	•	2	Bf. Location (S City or Tox		vumber or Hu	rai Houte Nuit	iber,
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 🗷 Certifying Phy	rsician: To the best of my	knowledge de-	th accurred at the	time date an	nd place =	nd due to the	called(c) c-	nd manner an	stated	
	Hos 24 ho Fun Fun	edicai	(Check only one)	iner: On the basis of exa- and manner stated.	mination and/or in	n occurred at the evestigation, in my	opinion, dea	ith occurre	d at the time,	date and pl	ace, and due	to the cause(s	à)
	o the ithin (Med	29b. Signature and title of certifier	and marrier stated.		29c. Licer	nse number			29d. Date s	signed (Month	, Day, Year)	
			1.13	Um. 11 -		\sim	600	617		Apri	,) 1.	2005	
	12		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	Print)	2	(-		-17-11			
			Samuel G. Maller,			sure Worl	ld Blv	d, Si	lver S	pring	, MD 2	0906	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Negistrar's S	Signature	astel							
	Regist	202	1	105 /	11 40	40							

			1- State of Maryland / Registrer	Department of H Certificate of L			ene () ()	5	3321
			Decedent's Name (First, Middle, Last)			2. Date of Death)		3. Time of Death 🧳
	Physici		Charles Luther STOTTLEMYER			Horil	. /	Year	7.30 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	repar	4c. County of	C	1, 2
1			Washington County Hospital	Ha	agerstown		Was	hingt	on
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplac	ce (State or Foreign
	Director		214-09-6702 ^{1₺м 2□F} 89	Yrs.		Oct. 15,	, 1915		yland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location				10d	. Inside City Limits
	Aaryli F sho	٥		agerstown					1 ☐ Yes 2 ☒ No
	28a-	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of W	hat Country	?
	death with the Maryland ms 23a or 28a-f show		11114 Mountain View Circle		L740		USA		
	ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hi		ecify Yes or No-	14. Race	- American	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Macical Examiner must be rullified at once.	by Fur	Armed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cubar	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	c, White, etc whi	
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7.	nin 72 in "in	Completed	(Specify only highest grade completed)	(Give kind of work done of life. DO NOT use retired,	luring most of work)	ing			
212	d with	E	Elementary/Secondary (0-12) College (1-4or 5+) 12 0	sheet metal w	vorker		aircr	aft m	fg.
Þ	othe vent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, M	laiden Surname	9)	
<u>la</u>	uld b Ments rrkad	<u>0</u>	Luther Irving Sottlemyer		Mary Al	ice Ride	nour		
ar	and has me	1 18	19a. Informant's Name/Relationship (Type, Print)	b. Mailing Address (Street a	and Number or Rur	al Route Number,	City or Town, S	State, Zip Co	ode)
Σ	and 2 salth n 27			11114 Mountai			agersto	wn, M	d. 21740
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of ery, crematory or other place	ө)	Date 2	Oc. Location - 0	City or Town	ı, State
<u>Ĕ</u>	Pag ment ant: I ury o	1 7		c Lawn Mem. P					Maryland
Baltimore,	Departi Import any inj		21. Signature of Funeral Service Licensee	22. Name and Addres		MINNICH			
ш	707.9	07	<u> </u>	415 E. Wil				Md. 2	1740
	Pnysician	3.5	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		g, such as cardiac		, ,	1n	pproximate iterval Between inset and Death) + 4 (AR)
	/Medical Examiner		Due to (1) is a consequence	e of):				16)tyears
	p =	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):					
	cate be executed physicien and s the burial-transIt	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	o offi					
8760,	cate be execu physicien and the burial-trar	E E	Sub to (or as a compaquence	5 OI).					
387	phys phys the	dicai	d						
P.O. Box (that the death certific ed by the attending f detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date Mon	of delivery th Da	ay Year
	v requires that the been signed by th should be detache	by Ph	Part II. Other significent conditions contributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did toba	acco use contri	bute to the o	cause of death?
rds	quires n signe ald be		Chipir obstructure	ulmman	drigue	1 ☐ Yes	s 2 □ No 3	3 🗌 Probabi	iy 4 □Unknown
000	≥ □ 05	Completed				24a. Was an	24b. W	ere autopsy	/ findings available
Be	The law ite has b	Juc				autopsy	ed? pr	for to compleath?	letion of cause of
tal		O	25. Was case referred to redical		26. Place of Deat	1 Yes 2		Yes 2	⊒ 1√0
5	ysicia s cer direct	0.0	examiner? 1 Yes 2 No Hospital: 1 Mapatient 2 ER/C	Outpatient 3 DOA Othe	er: 4 Nursing Ho			r (Specify)	
0	g Ph er thi	=	27. Manna of Death 28a. Date of Injury 28b	. Time of 28c. Injury	at	28d. Describe how			
io	ath. r: Aft	atio	1		res 2□No				
Division of Vital Records,	afor Atte after de Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stre City or Town,		r or Rural R	oute Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Gertifying Physicien: To the best of my knowled and manner stated.	ge, death occurred at the time and/or investigation, in my op	ie, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and man te and place, ar	iner as state nd due to the	e cause(s)
	To the Within To the comp	Me	29b. Signature and title of certifier	29c. License	357 U	29	d. Date signed	(Month, Day	y, Year)
064	-5		30 Name and address of person who completed cause of death (Item 23a	(Type, Print)	IM ITHICAL	NKE, M	n 21+	-83	
	- 💪 Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1				-	
	Registr	411	31. Date fred (Month, Day, Year) APR 06 2005 32. Registrar's Signature	Specks					

Physici				PER FHC		42 47401			Rag. No.		
	ian	1. Decedent's Name (First, Middle, Las	JESSIE M	AE SPARGI	ER			Date of De. Month	ath Day	Year	3. Time of Deat
/Medic		1456	par	36				march	2579		
Examir	ner	4a. Facility Name (If not institution, give		the las	4b. City, To	own, or Location of Balt		_	4c. Co	unty of Deat	h
		5. Social Security Number 6. Se		In yrs. last birthday	v) If Under 1				PR OI	1030	hplace (State or Fore
Funeral Director			□M 2X1F 74			Days Hours	Min.	8. Date of Big (Month, Da	v, Year) 1 ,1 93(- 60	TH CAROLI
		Usual Residence of Decedent						001. 1	1,1700	, , ,	III OIIIOIII
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel; or items 23e or 28a-f show other treumatic event, the Medical Exprenent rust be a pullish at	ctor	10a. State 10b. County		Oc. City, Town or I	Location						10d. Inside City Lin
		MARYLAND HOWARD		JESSUP							1X☐Yes 2 ☐
	ai Dire	10e. Street and Number 9403 Spring Water	Path		10f. Zip C	ode .0794			10g. Citizer US	of What Co SA	untry?
	e Completed by Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	3. Was Deceder	nt of Hispanic Orig	in? (Spec	cify Yes or No	14.	Race - Ame Black, White	rican Indian,
or its		1 ☐ Never Married 2 ☐ Married	1 ∐Yes 24 No If Yes, Give		1 ☐ Yes 2		, , , , , , , , , , , , , , , , , , , ,		Sp	ecify:B1a	
urei'.		3 ☐ Widowed 4 🛣 Divorced	Year or Dates:								
"net		15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Giv	cedent's Usual (ve kind of work . DO NOT use	done during most	of workin	g	16b. Kind	of Business/	industry
than		Elementary/Secondary (0-12)	College (1-4or 5+)		smetic	76(#64)			Priva	a t o	
al Hygiene. I other than " vent, I'le Mei		9th 17. Father's Name (First, Middle, Last)		1 00	SINECIC	18. Mother	r's Name	(First, Middle,			
sold of cover	o Be	James Bartley Volia Ellis							,		
and Mentalis marked	2	19a. Informant's Name/Relationship (7	Type, Print)	19b. Ma	iling Address (5	Street and Number	r or Rural	Route Number	r, City or To	wn, State, Z	ip Code)
Health a		Willie Weston Pat	terson/son	4904	Blount	Vista C	ct. J	ackson	ville:	F1 3	2225
f Heg		20a. Method of Disposition		20b. Place of Disp	position (Name rematory or other	of er place)	Da	ate	20c. Locat	ion - City or	Town, State
nt: ff ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		Metropol	•	1 1	4-4-	2005	Alexai	ndria.	VA
Department of H importent: If ite eny injury or ot once.		21. Signature of Funeral Service Licen				Address of Facility					
Depa impo eny ii		Symbol Car	exce-11			itland R		uitlan		2074	
1		23a. Part1. Enter the disease, or comp	plications that caused the	ne death. Do not e	enter the mode	of dying, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between
Pnysician		Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a multiple base breum on 15							Onset and Dea		
Medical		disease or condition resulting in death)		consequence of):	phe	im Dhi	1				aus
kaminer		O THE PLAN BY	· Chamir	bheta	ullue :	Dhymane	and	disc	arsa.		Urcies
cate be executed chysician and the burial-transit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								9	
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C 00		resulting in death) Last Due to (or as a consequence of):									
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hysiciar the burit	dica	· ·	d								
ling physician and e as the burial-transit	Medicai	IF FEMALE:	d								
ittending or use as	ian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	3 Ectopic preg				23d	. Date of deli	very Day Year
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4	Registrar		Cei	tificate of De	ealli		Reg. No.			
	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day						Year	3. Time of Death		
Physician /Medical	Ralph Eugene Tolliver					April	2	2005	4:35 pm ^M	
	a. Fecility Name (If not institution, giv	street and number)		4b. City, Town, or Lo		1	1	ounty of Death		
	St. Thomas More	15.4	to a bind to b	Hyattsville H Under 1 Year H Under 24 Hrs. 8. Date of E			Prince Georges			
Director	223-44-3193	ex 7. Age (In yrs. Mg M 2□F 68	Yrs.		s Hours Min. (Month, Day,			9. Birthplace (State or Foreign Country) 1936 Galax, Virginia		
0 –	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits	
Mary Fe sh	DC Washington								1 F Yes 2 No	
with the Mar s or 28a-f s be notified Director	0e. Street and Number		10f. Zip Code		10g. Citizen of What Country?					
th wit	3005 Bladensburg	Rd. NE # 709		2001	18		USA			
Fur Fur	1. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Nas Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2점 No	panic Origin? (S) Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		. Race - Ameri Black, White, pecify:	etc.	
urel; o	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			1 40 20 44 44 44 40				Black 16b. Kind of Business/Industry		
n 72 in at enice enice enice	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				165. Kind of Business/Industry		
ed within 72 ho ygiene. Ser than "natur. I, the Medical Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4yrs			Social Worker				Gov't		
filled vi Hygie other cont.	17. Father's Name (First, Middle, Last,			ne (First, Middle,	le, Maiden Sumame)					
Viant build be Mental arked a atic ev	Eugene Tolliver				Edna (Edna Carter				
shot shot umal umal	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
and 2 alth alth 27 i	Vivian Tolliver/		A CANADA CONTRACTOR OF THE PARTY OF THE PART	Bladensbur						
Tite in the second seco	20a. Method of Disposition ©∰Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispo cemetery, crer	sition (Name of natory or other place)		Date	20c. Loca	tion - City or To	own, State	
Pages Pages ment of ant: If it ury or o	'4 □Donation 5 □ Other (Specif	Qua		Nat. Ceme.		8,2005		ngle, V		
Dartimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy St NW Washington, DC 20011									
	23á. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
(Pitaletates)	Immediate Cause (Final disease or condition)									
/Medical	resulting in death)						1201013			
Examiner	Sequentially list conditions b.									
sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss or triur)	Due to (or as a conseq	uence of):							
executed in and inatransit	that initiated events resulting in death) Last	c								
ificate be executed graviticate be executed as the burial-transit.										
oo / ov ifficate be g physicia as the bur ledicai		0								
eath cert attending for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1					230	23d. Date of delivery Month Day Year		
ires that the d signed by the d be detached the drached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						obacco use	co use contribute to the cause of death?			
The law requires I the law requires I the law requires I the has been signs age 2 should be completed by	71311	19-313				24a. Was	an s	24h Were autr	oney findings available	
has has mp						autop	rmed 🚱 📗	death?	opsy findings available ompletion of cause of	
	25. Was case referred to medical				De Diago of Dag	1 Yes		1 🗆 Yes	2∐ No	
ysician: ysician: is certific director,	25. Was case referred to medical examiner? 1 Yes 2 No									
I or Attending Phy after death. Director: After this in by the funeral of the fu	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	e of 28c. Injury at 28d. Describe how injury occurred					77	
DIVISION C ppitel or Attending P ours after death. teral Director: After t filled in by the tuners al Certification;	3 Suicide 6 Could not b	ome, farm, str fy)	me, farm, street, factory, office 28f. Location				(Street and Number or Rural Route Number, own, State)			
Hospite 24 hours 5 Funeral stely filled dical C	29a. Certifier (Check only one) 29a. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
# ∈ # ₽ 9							29d. Date s	Date signed (Month, Day, Year)		
₩ s ⊨ ō	Paul I	mules/or	el la	LD O	125	2	APR	ih (=	2005	
(2)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DEVORE MD 4703 Chusensbury Rd Hyattsui IIEM)								(UN 2028)	
							- 110/1 1 / /			

		•	1 - For Unpend Item Registrar	23a&27 per	r me G842°4 Ce	arment of Heal rtificate of Dea	th and Mental F a <i>th</i>	lygiene Reg. No.	005	13324
	Physici		1. Decedent's Name (First, Middle, Last) Benjamin Joseph			2. Date of Dea Month Thomas April 1			Day Year	
	/Medic Examir		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Loca	4c.	4c. County of Death		
	Funeval		437 Walnut Street 5. Social Security Number 6.		ge (In yrs. last birthday)	Cumberland			Allegany County	
9	Funeral Director		216-66-1185	1ĂM 2□F	52 Yrs.	Months Days Ho	urs Min. (Month, 09/27	Birth Day, Year) /1952	Cour Maryl	lace (State or Foreign htry) and
0	aryland ahow sd at		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	h the Marylar r 28a-f ahow r notified at		MD Alles	gany	Cı	mberland	1 🕅 Yes 2 🗆 No			
	death with the Maryland ms 23e or 28a-f ahow Ir-tust Le notified at	Director	10e. Street and Number			10f. Zip Code	24.500		zen of What Coun	itry?
	death ms 23	Funeral	437 Walnut St:	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispani	21502 ic Origin? (Specify Yes or exican, Puerto Rican, etc.)		USA 14. Race - Americ	
036	or Ite	by	1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces: 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No1970-		exican, Puerto Rican, etc.)		Black, White, Specify:	otc. √hite
5-0	n 72 hours "natural",	To Be Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Kir	nd of Business/Inc	dustry
Maryland 21215-0036	filed within I Hygiene. othar than ant, Ihe Ma		Elementary/Secondary (0-12)	College (1-4or	5+)	elf-Employed		Ca	rpenter	
Dd 2	be filed within tal Hygiene. Id other then event, It is Me		17. Father's Name (First, Middle, Las	")	,		Mother's Name (First, Mide			
yla	2 should be to and Mental It is marked of raumatic eva		Richard	D.	Thomas		/irginia	С.	Whetz	
	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 ia marke any Injury or other traumatic: <u>once</u> .		19a. Informant's Name/Relationship Richard D. Thomas /				umber or Rural Route Nur Cumberland, Ma			Code)
Baltimore,	es 1 ar of Hea fitam r othe		20a. Method of Disposition 1 🏅 Burial 2 □ Cremation 3 [□ Bomoval from State	20b. Place of Dispo		Date		cation - City or To	wn, Slate
ij	tment tant: I		' 4 ☐ Donation 5 ☐ Other (Special	fy)	MD Vet. Cen	@ Rocky Gap	04/18/2005		intstone,	
Bai	permit. Departr Imports any Inji		21. Signature of Funeral Service Lice	nsee	22		facility Adams Fam. reet, Cumberla			
	Enysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only be cause on each line. Approximate Interval Between Onset and Death							
			Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):							
-	Examiner		Sequentially list conditions	b	a concequence or,					
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
Ć.	The law requires that the death certificate be executed the has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
68760,		edicai								
	eath certific attending p		IF FEMALE:	23c. If yes, outcome	of pregnancy			,	3d. Date of delive	0,
P.O. Box	s that the death ned by the atter s detached for u	Medical Certification: To Be Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1					Month Day Year		
rds, P	w requires that been signed t should be det		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∭Unknown		
Vital Records,	The law reate has been						, pe	as an topsy rformed?	24b. Were autop prior to con death? 1 1 Yes	osy findings available inpletion of cause of
/ital	ysicien: Th is certificate director, pag		25. Was case referred to medical examiner?				Place of Death (Check onl		- X-00	
	× = =		1 X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji			□ Nursing Home 5 □ Re 28d. Describ			At scene
ion	Attanding r death. sctor: After by the fune		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ay Year) Injury	f 28c. Injury at Work? M 1 Tyes	2 🗆 No	, ,		
Division of	spital or Attanding Phous after death. naral Director: After th		3 Suicide 6 Could not 1 4 Homicide determined	28e. Place of in	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		(Street and Town, State)	Number or Rural	Route Number,
	To the Hospital or Attandi within 24 hours after death. To the Funaral Director: A completely filled in by the fu				of examination and/or in		te and place, and due to the death occurred at the time			
	To th To th comp		29b. Signature and title of certifier	mid		29c. License num	ber		signed (Month, L	
					death (lize - 00.) 7	OCME		Apr	il 14, 2	005
			30. Name and address of person who	mi >	оватп (пёт 23а) (Туре,	111 Penn	Street Bal	timore	e, Maryla	and 21201
	Sta Registr		31. Date filed (Month, Day, Year) APR 19	32 degist	rar's Signature	ede				

			For State Registrar	State of Ma	-	artment of Hea			ne 0 0 5	13325
	, Dhysisi	12.1	1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		Pau1	Andrew	Un	derwood		March 31,		5:29 P M
	Examin	ęr	4a. Facility Name (If not institution			4b. City, Town, or Lo			4c. County of D	
4 A.		¥	Ft. Washington 5. Social Security Number	-	e (In yrs. last birthday	Ft. Washi	INGTON f Under 24 Hrs.	R Date of Birth	Prince	George's Birthplace (State or Foreign
	Funeral Director		577-68-8481	1 X M 2 ☐ F	52 Yrs.		Hours Min.	8. Date of Birth (Month, Day, Y Feb. 7, 1	(953 W	Country) ashington, DC
			Usual Residence of Decedent					, ,		, , , ,
	inylan show	_	10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
	Ba-f s	cto	Maryland Prince	George's	Ft. Was					1 □ Yes 2√3 No
	with the sor 2 De ro	Funeral Director	10e. Street and Number 9451 Allentown	Pand		10f. Zip Code 20744		10g	. Citizen of What USA	Country?
	eath v	eral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13		anic Origin? (Spe	acify Yes or No-		merican Indian,
10	r Item	Fun	1 □ Never Married 2 📉 XMarr	Armed Forces? ied 1 ☐ Yes 2 🛣 N		Was Decedent of Hispa If Yes, specify Cuban,		Rican, etc.)		/hite, etc.
036	el', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
5	within 72 hours after death with the Maryland ane. then "naturel", or Items 23s. or 28a-f show he Madical Exami her must be notified at	Completed	15. Deceden (Specify only higher	t's Education st grade completed)	(Giv	edent's Usual Occupation	on ing most of worki	ng 16	b. Kind of Busine	ess/Industry
2	vithin ne. hen '	mpl	Elementary/Secondary (0-12)	College (1-4or 5	(+)	DO NOT use retired) ock Handler	•		Xerox	Corn
i T	illed v Hygie ther t nt, th	ပိ	12th 17. Father's Name (First, Middle,	Last)	51			e (First, Middle, Ma		COIP.
an	d be antal	To Be	Paul M. Underv					a A. Mind		
Maryland 21215-0036	shoul nd M marl	-	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mai	ing Address (Street and	d Number or Aura	Il Route Number, C	City or Town, Stat	e, Zip Code)
	and 2 alth a 127 ic er tre		Charlotte S. Un	nderwood / Wi	ife 9451	Allentown	Road Ft	. Washing	gton, MD	. 20744
ore	of He of Her r oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 DRemoval from State	20b. Place of Disp cemetery, cr	osition (Name of ematory or other place)		- 1	c. Location - City	
Ĕ	Pag ment ent: I		' 4 ☐ Donation 5 ☐ Other (S	pecify)	Kalas Cr	•	04/05/			, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel, or Items 23s. or 28a-f show emprorent: If item 27 is marked other than "naturel, or Items 23s. or 28a-f show empty injury or other treumatic event, the Medical Examins must be notified at once.		21. Signature Funeral Service	Licensee		2. Name and Address	of Facility George	P. Kalas	Funera	1 Home P.A.
	2020a		23a. Part1. Enter the disease, or	cess		6160 Oxon J	Hill Roa	<u>d Oxon Hi</u>	11, Mar	yland 20745 Approximate
			shock, or heart failure. List	only one dause on each lin	ne.	ther the mode of dying,	sucri as cardiac c	or respiratory arrest		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	1 E S	DISER	75E			
	Examiner			Rue to (or as	a consequence or):	1 class	films	est:		
	, es	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (ar as	a consequence of		1	1		
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	U	14.4				
Ö,	ate be executed thysician and the burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequence of):					
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dlcal		d						
9 X	that the death certifics ed by the attending pl detached for use as t	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of	delivery
Вох	atter atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	t the c by the achec	hysi	9 Unknown	9□ Unknown						
ď.	res tha igned I be det	by P	Part II. Other significant condition	ns contributing to death be	ut not resulting in the	underlying cause given	in Part I.	23e. Did tobac	cco use contribut	e to the cause of death?
ord	w require been sig should t							1 🗆 Yes	2 □ No 3 □	Probably 4 Unknown
Vital Records,	e law r has be je 2 sh	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
<u>~</u>		Con						performe 1 Yes 2	d? death No 1□	Yes 2 No
Vit	yeicien: The is certificate hadirector, page	Be	25. Was case referred to medica examiner?	Hospital	1			(Check only one)		
o	Attending Phyeicien: r death. ector: After this certific: by the funeral director, I	1: To	1 Yes 2 No	1 ∐ Inpatie	ry 28b. Time			me 5 ☐ Residend 28d. Describe how		Specify)
on	nding Ph th. : After this funeral	tlor	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, Day	y Year) Injury		s 2 No			
Division	or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of Inju-	ury - At home, farm, s	treet, factory, office		28f. Location (Stree City or Town, S	et and Number of	r Rural Route Number,
	rs afte el Dir	Cert		Dunding, Cit	o. (Cpoony)				,	
	Hospitel 24 hours a Funerel I	edical	(Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of	examination and/or					
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Med	one) 29b. Signature and title of certifie	and manner sta	ated.	29c. License n	umber	29d	. Date signed (M	onth, Day, Year)
	7 × 7 ⊗		\$ 61, 72.	P/nis	Ken n	p mn	8300	7	4-1.	-175
2	(20)		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type	Print)	0 25	1		
ا	20		EDWARD L-	MOSLEY	MD	10111 h	100d Lo	urel h	lay- (30wie 20271
	Sta		31. Date filed (Month, Day, Year, APR 0 5	2005 A. Registra	ar's Signature					
	Registi	ar	AFR U J	.vis	No Age					

		State of Maryland / Department of Maryland / D			2005 1332
Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 2005 3. Time of De 5:40
/Medio Examin		KATHERINE EDNA VALENTINE 4a. Facility Name (If not institution, give street and number) 7793 FAIRPLAY ROAD	4b. City, Town, or Location of Death FAIRPLAY		4c. County of Death WASHINGTON
Funeral Director		5. Social Security Number 214-34-2255 Usual Residence of Decedent 6. Sex 1 M 2 S F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye JAN. 9, 1	9. Birthplace (State or Fo Country) MARYLAND
e Maryland le-f show iiilied al	ctor	10a. State 10b. County 10c. City, Town or Lo MARYLAND WASHINGTON	cation FAIRPLAY		10d. Inside City L 1 ☐ Yes 2]
with th	Dire	10e. Street and Number 7793 FAIRPLAY ROAD	10f. Zip Code 21733	10g.	Citizen of What Country? U.S.A.
within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show fa Madical Exertinar mast be maiffied at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spet f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
ithin 72 hou ie. ien "neturi Medical E	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing 16b	. Kind of Business/Industry
be filed Ital Hygi of other evant, I	Be	6 17. Father's Name (First, Middle, Last) ED ANCTS MADTIN PROGN		(First, Middle, Maid	OWN HOME
nd 2 should lith and Me 27 is mark r traumati	2	MARY K. MAY/DAUGHTER 18418	ng Address (Street and Number or Rure B BREATHEDSVILLE R	OAD, BOON	• 10
Page ment o ant: If ury or		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 1 □ Doration 5 □ Other (Specify) 21. Sign ture of Fureral Segric Centure 22.	REEK CEM. 4/11/ 2. Name and Address of Facility	2005 НА	AGERSTOWN, MARYLANI national Pike
permit. Departi Import any inj		Paul M. Dean B.	AST FUNERAL HOME	Boonsboro	o, Maryland 21713 Approximate Interval Between
Bath certificate be executed to attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Medi		Dectopic pregnancy Other (specify)		23d. Date of delivery Month Day Yea
w requires that the bound by should be detained by	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of deat
	Completed			24a. Was an autopsy performed 1 □ Yes 2 ☑	
ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	n <i>(Check only one)</i> me 5 V. Reside nce	3 6 ☐ Other (Specify)
ing Ph After th uneral	Certification; T	27. Manner of Death Natural 5 Pending 2 Accident 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred t and Number or Rural Route Number
a High		4 Homicide determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	h occurred at the time, date and place,	City or Town, St	e(s) and manner as stated.
To the Hospitel Within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier		ed at the time, date	and place, and due to the cause(s) Date signed (Month, Day, Year)
1D		30. Name and address of person who completed cause of dyath (Item 23a) (Type,	Print). MULL Street He		4-8-05 4-8-05
Sta Registi		31. Date filed (MoAM), Day, Year) APR 0 8 2005 APR 0 8 2005	perter	Tour Court	

			1 = For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of H			giene leg. No: 005	13327
	Physici	an	Decedent's Name (First, Middle					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Mary Celeste W		()	# C' T			29, 2005	2:10 p M
	Examin	er	4a. Facility Name (If not institution		Der)	4b. City, Town, or		tn	4c. County of Dea	
-	Funeral		5809 89th Aver 5. Social Security Number		. Age (In yrs. last birthday)	New Cari	If Under 24 Hrs		Prince (thplace (State or Foreign
	Director		214-34-6575	1□M 2XF	66 Yrs.	Months Days	Hours Min	Month, Day April 12		ountry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Li	ocation				10d. Inside City Limits
	daryik f sho	٥								1 XYes 2 No
	r 28e-	Director	Maryland Prince 10e. Street and Number	e George s	New Carr	10f. Zip Code		1	log. Citizen of What Co	ountry?
	h with		5809 89th Avenu	ie		20784			U.S.A.	
	ems arms	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
36	d within 72 hours after death with the Maryland Jiene. r then "naturel", or Items 23a or 28e-f show The Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Mari 3 🕅 Widowed 4 ☐ Divorced	ried 1 ☐ Yes :	2 [X] No	1 ☐ Yes 2 ☑ No	Specify:		0 "	White
00	ture!			t's Education	16a, Dece	dent's Usual Occup	ation		16b. Kind of Business	
215	within 72 ene. then "ne	plet	(Specify only highe: Elementary/Secondary (0-12)		life	kind of work done of DO NOT use retired	during most of wo	orking		,
213	filad withir Hygiene. rther then	Completed	12			unting Cl	Lerk		Darcars	
nd	be filad value Hygie	Be	17. Father's Name (First, Middle,	Last)				me (First, Middle, i	Maiden Sumame)	
Maryland 21215-0036	2 should be to and Mental I le markad or reumatic eve	2	Henry Hellman 19a. Informant's Name/Relations	hin (Tuna Brint)	10h Maili	as Address (Street	Margar		r, City or Town, State,	Zin Cada)
Ma	d 2 si th an th an 27 le r treur		Charles Wood -	_					:1, Marylan	
ē,	gas 1 and 2 should t of Health and Mer If item 27 le marks or other treumatic		20a. Method of Disposition		20b. Place of Dispos	osition (Name of	riew Cou.		20c. Location - City or	
E O	Pagas nent of I int: If its iry or o		1 🖫 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		late		l l	/6/2005	Cheltenham	. Marvland
Baltimore,	permit. Pagas Department of Important: If i any injury or once.		21. Signature of Funeral Service	Licensee					neral Home	
<u>m</u>	89889		H lonsle	ance 1	Jasch 4	739 Balti	more Av	e., Hyatt	sville, MD	20781
Ц			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death. Do not en ch line.	ter the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		static Non-S	Small Cell	l Lung C	ancer		
	Examiner			Due to (d	or as a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter throughlying Cause (Disease or injury	b. Due to (c	or as a consequence of):					
	ocutad nd transil	Examine	that initiated events	c						
8760,	cate be executad obysician and the burial-transit		resulting in death) Last	Due to (d	r as a consequence of):					
687	death certificate be executad e attending physician and of for use as the burial-transil	Physician/Medical		d						
Box (eath certifica attending ph I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				23d. Date of de	livery
		icia	in the past 12 months? 1 ☐ Yes 2 X No	4☐Pregna	nt at time of death 5[Ectopic pregnancy Other (specify)			Month	Day Year
P.0	requires that the de een signed by the a hould ba detached	Phys	9 Unknown	9□ Unkno						
	ires tha signed I ba del	by	Part II. Other significant condition	ons contributing to dea	ath but not resulting in the c	inderlying cause giv	en in Part I.		bacco use contribute to	o the cause of death? robably 4 DUnknown
Ö	w requir been si should	eted	•					81		
Rec	e la has je 2	ompleted						24a. Was a autops perfori	sy prior to med? death?	utopsy findings available completion of cause of
tal		ပိ	25. Was case referred to medica	1			26 Place of De	1 ☐ Yes :	1	: 2□ No
of Vital Records,	Physicien: this certific al director,	To B	examiner? 1 □ Yes 2 X No	Hospital:	patient 2 ER/Outpatie	nt 3 DOA Oth	The second secon		ence 6 □Other (Spe	cify)
			27. Manner of Death 1 X Natural 5 ☐ Pendir	28a. Date o	f Injury 28b. Time of Injury	f 28c. Injun Wor	v at		ow injury occurred	
sio	Attending r death. sctor: After by the fune	cat	2 Accident investi 3 Suicide 6 Could	gation not be			Yes 2 □No	20f Lanatina (C)	Avenue A con of Alicember O	On the Market
Division	P afte	ertification;	4 ☐ Ho <i>m</i> icide determ	nined 286. Place	of Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		City or Town	treet and Number or R n, State)	urai Houte Number,
	spite ours serel filled	0		ng Physician: To the	pest of my knowledge, deal	h occurred at the tin	ne, date and plac	e, and due to the c	ause(s) and manner as	s stated.
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medical one)	Exeminer: On the ba and mann	sis of examination and/or in er stated.	vestigation, in my o	pinion, death occ	urred at the time, d	ate and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie			29c. Licens	e nu <i>m</i> ber	2	9d. Date signed (Mont	th, Day, Year)
0			Matt	X			58603	A	April 4, 20	005
R			30. Name and address of person				ahinatan	DC		
	Sta	te	Matthew Kester 31. Date filed (Month, Day, Year)	3. Re	gistrar's Signature	- was	PHITHERON	, DC		
1	Registr	, "	APR 05	2005	April April					

			1 - For State Registrar	ate of Maryland /	Certificate of Death		ygle ne	0 13328
	Dhysiai		Decedent's Name (First, Middle, Last)			2. Date of D	-	3. Time of Death
	Physici /Medio			Mite		Apri		5 4:38 PM
	Examir	er	4a. Facility Name (If not institution, give street		4b. City, Town, or Location	O 1	4c. County of	Death
			5. Social Security Number 6. Sex				int	District to 5
	Funeral Director		5. Social Security Number 6. Sex 12.2-16-7817	7. Age (In yrs. last b	Yrs. Months Days Hours	Min. 8. Dale of B (Month, D June	2 1912 I	B. Birthplace (State or Foreign Country) Maryland
	land ow		10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Limits
	Mary P-f eh	tor	Maryland Worceste	er Bei	clin			1 ☐ Yes 2 📉 No
	th the	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Wh	at Country?
	23a c	ai	10236 Camelia Lar	ie	21811		U.S.A	
	r dea	nue	A	as Decedent Ever in U.S. med Forces?	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	origin? (Specify Yes or Nan, Puerto Rican, etc.)	lo- 14. Race - Black,	American Indian, White, etc.
36	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or flems 23a or 28e-f ehow ther, the Medical Examinar must be notified at	by Fi		Yes 2 No Yes, Give	1 ☐ Yes 2 X No Specif	y:	Specify:	Dlagl
8	tural	edk	15. Decedent's Education	ear or Dates: WW 2	a. Decedent's Usual Occupation		16b. Kind of Busi	Black
15	nin 72 n "ne Medik	piet	(Specify only highest grade con	ollege (1-4or 5+)	 Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) 	ost of working	, , , , , , , , , , , , , , , , , , , ,	,
212	d with glene. er thar	Completed	10	0/1898 (1-401 0+)	Laborer		None	
Maryland 21215-0036	be filed stat Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)			her's Name (First, Middl	e, Maiden Sumame)	
<u></u> ₹	2 should be and Mental is marked c aumatic eve	일	Charles White			ola Smack		
Mai	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Type, F		b. Mailing Address (Street and Num.			
	1 and Health em 27 kher tr		Gwendolyn Steele (20a. Method of Disposition		of Disposition (Name of ery, crematory or other place)	Date	20c. Location - C	
οu	Pages nent of h ant: If its ary or of		1 ■Burial 2 □ Cremation 3 □ Removed 4 □ Donation 5 □ Other (Specify)	ai iiuiii State		4-8-05	Berlin,	
Baltimore,	4 t t f f		21. Signature of Funeral Service Licensee	IVCW I				
ä	Depar Depar Impo any ir		Bladese B. &	tunert	Stewart Fun 821 West Rd	eral Home .Salisbur	y,Md.218	01
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do	not enter the mode of dying, such a	s cardiac or respiratory	arrest,	Approximate Interval Between
屋	Pnysician		Immediate Cause (Final disease or condition	Seosis				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	∍ of):			2)
	Lxammer	L	Sequentially list conditions, b.	Kenal Fa	Juso			2 days
	led Isit	nine	Sequentially list conditions, if any, leading to immediate rausa Enter Industrying Cause (Disease or injury	Due to (or as a consequence	Fr. 1. 1.00			2 Law.
	xecul and al-trar	xan	that initiated events c resulting in death) Last	Due to (or as a consequence	e of):			13
68760,	e be e siciar e buri	edicai Examiner	d	- 1				
.89	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ledic						
Вох	attendin for use	an/N	23b. was decedent pregnant	yes, outcome of pregnancy □Live birth 2 □Fetal deat	th 3 Ectopic pregnancy		23d. Date of	
	es that the death cer igned by the attendir be detached for use	Physician/	1 Yes 2 No	☐Pregnant at time of death ☐Unknown	5 Other (specify)		Month	Day Year
P.0	d by t	Phy	9 Unknown	ting to doub but got reculting	in the underbies acres are in Dec	al 220 Did	tabassa usa santub	ute to the cause of death?
JS,	ires ti signe d be d	by	Part II. Other significant conditions contribu		with an underlying cause given in Pan		_	☐ Probably 4 ☐ Unknown
0.00	w requir been si should	etec	O all I all	a1 gar 100				
Records,	has law	Completed	Cellulity			24a. Wa auto perl	opsv prid	re autopsy findings available or to completion of cause of ath?
a			25. Was case referred to medical		00.7%		2 No 1L	Yes 20 No
of Vital	Physicien: this certificatel director,	To Be	examiner? 1 Yes 2 Ne	al: 1 ☐ inpatient 2 ☐ ER/O		ce of Death <i>(Check only</i> Nursing Home 5 Res		(Specify)
	ding Phy h. After thi funeral		27. Manner of Death 28		. Time of 28c. Injury at Injury Work?		how injury occurred	
io	Attending r death. ector: After by the fune	atio	2 Accident 5 Pending investigation	(Month, Day real)	M 1 ☐ Yes 2 [□No		
Division	l or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 28	e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		(Street and Number own, State)	or Rural Route Number,
	Hospitel or 24 hours afte Funerel Dir tely filled in I							
	Hospite 24 hours Funerel stely filled	edical	(Check only 2 Medical Examiner:	 To the best of my knowleds on the basis of examination a and manner stated. 	ge, death occurred at the time, date a und/or investigation, in my opinion, de	and place, and due to the eath occurred at the time	e cause(s) and mann , date and place, and	er as stated. d due to the cause(s)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Med	29b. Signature and title of certifier	mainer stated.	29c. License number	r	29d. Date signed (Month, Day, Year)
	- s - ō		Karyna Mo	rez Da	RES-	D000	April	1.2-005
	23		30. Name and address of person who comple		(Type, Print)	1 + 4	April timore	1,000
_	- 2		Karish Misne	2,00.	Sina Harpito	4 of Bal	Linore	>
	Sta		31. Date filed (Month Pay Year) 6 2005	32. Pigistrar's Signature	South			

			1 - Stete Registrar	State of Maryland	-	artment of He tificate of D		_	giene Reg. Nö.	005	13329
	Physici	an	1. Decedent's Name (First, Middle, Last)	shoth Day	,	Uood		2. Date of De Month		Year	3. Time of Death
	/Medic	al				Wood	10.00	April	4,	2005	8:45 P M
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, or i				County of Death	
	Funeral		Beverly Health Care 5. Social Security Number 6. Sex		st birthday)	Freder	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign
В	Director		212-38-7693	M 2 X) F 86	Yrs.	Months Days	Hours Min.	(Month, Da		B Penn	sylvania
	p .		Usual Residence of Decedent	100 Cin	Town and a						
	laryla shov	'n	10a. State 10b. County Maryland Frederick		Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the N	Director	10e. Street and Number	****		10f. Zip Code		 T	10a Citiz	zen of What Cour	
	filed within 72 hours after death with the Maryland Hygiene. strier then "naturel", or Items 23s or 28e-1 show ant, the Medical Examinar must be multified at	I Di	11111 West Baldwin	Road			21774			ed Stat	
	death	Funeral	11. Marital Status	Was Decedent Ever in U.S Armed Forces?		Vas Decedent of His	panic Origin? (Spe	ecify Yes or No		4. Race - Americ	can Indian,
9	after or Ite	/ Fu	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		fYes, specify Cuban I□Yes 27□No	Specify:	nican, etc.)		Black, White, Specify:	etc.
21215-0036	hours urel',	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:						Whi	
1 5-	n 72 n nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occupat kind of work done du DO NOT use retired)	ion uring most of worki	ing	16b. Kin	nd of Business/Inc	dustry
712	with liene	omi	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	T	eacher			Pub	olic Sch	ools
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle	Maiden S	Sumame)	
<u>la</u>	Ments Ments arkad	To	Raymond P. Day				Nadine	Taylor			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23s or 28e-f show appringury or other treumetic event. It a Madical Examinat must be notified at ODGe.		19a. Informant's Name/Relationship (Type Susan Wilson - Day			g Address (Street an			-		Code) t, MD 21774
e)	1 and 1ealth sm 27 thar t		20a. Method of Disposition			sition (Name of		ate 10		eation - City or To	
altimore,	ages nt of i t: If it		1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	metery, cren	natory or other place)				
Ħ	artme orten injun		4 □ Donation 5 □ Other (Specify)21. Signature of Fuheral Service License		22	ily Cemeto . Name and Address	of Facility				Maryland
B	Dep Imp eny		Told of	Un	0.	lin L. Mo 6401 Ridg	lesworth,				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.						20072	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cerebral Va	scula	r Acciden	t				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque							
н	ZXumiii	-	Sequentially list conditions.	Intra-Crani		eed					
	nsit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Failure to	,	2					
Ć	exect an and rial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequent							
8760,	icate be executed physician and s the burial-transit	dical	d.								
9	artifica ing ph e as th	Med	IF FEMALE:								
Вох	eath certific attending p for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			2	 Date of delive Month 	Pry Day Year
0	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	atn 5	Other (specify)					
<u>α</u>	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	y Ph	Part II. Other significant conditions conf	ributing to death but not resul	lting in the ur	iderlying cause giver	n in Part I.	23e. Did t	obacco us	se contribute to th	ne cause of death?
Records,	quires nn signe uld be	ed by						1 🗆 '	Yes 2¶Z	No 3□Prob	ably 4 \to Unknown
000	law requir as been si 2 should	Completed						24a. Was		24b. Were autop	psy findings available
Ä		mo:						autor perfo 1 ☐ Yes	rmed? 2½ No	death?	inpletion of cause of
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only o			
	ding Physicien: After this certifica funeral director,	٩	1 ☐ Yes 212 No		R/Outpatien		4 / Nursing Hor			Other (Specify)
nc	ding l	tion	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work: M 1 □ Y	at es 2 □No	28d. Describe I	now injury	occurred	
Division of	l or Attendater deatl Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	ne, farm, stre			28f. Location (Street and	Number or Rura	l Route Number,
ă	el or A	erti	4 Homicide	building, etc. (Specify)				City or Tov	vn, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	icien: To the best of my know er: On the basis of examination	rledge, death	occurred at the time	, date and place, a	and due to the	cause(s) a	and manner as st	ated.
	the H nin 24 the F nplete	ledical	one)	and manner stated.	on and/or my						
	To To	Σ	29b. Signature and title of certifier			29c. License				signed (Month, I	
	. (JW'T	related as a set to see	00-) 7	D004	7901		whrij	L 5, 200.	,
	19		30. Name and address of person who cor Sibte A. Kazmi, MI				erick, Ma	aryland	2170)1	
	Sta	te	31. Date filed (Month, Day, Year) 6 20	32. Posistrar's Signatu	ıre						
	Registr	ar	7111 0 0 20	The state of the s	A A	2005					

			For Stete Registrar	State of M	laryland		artment of H		and Me	_	gierje Reg. No.	05	1330	30
	Dhusisi		1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of I	
	Physici /Medic		KATHE MARGAR	ETTE WEHN	JER				Z	April	_	2005	7:40	a^{M}
	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, or	Location o	f Death	_	4c. Co	ounty of Death		
			113 Eighth Stre	et			Pocomoke	City			Wo	rceste	er	
	Funeral Director		212-42-0873	5. Sex 7. A 1 □ M 2 🛣 F	ige (In yrs. Ia 7		If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Dec. 3	th y, Year) 1930	9. Birth Con Gern	nplace (State or untry) nany	Foreign
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ecation						10d. Inside City	v I imits
	faryli sho	5											1 X Yes	
	the N	Director	MD Worces 10e. Street and Number	ter	Poco	moke (10f. Zip Code				10s Citizes	of Miles Co.	untar2	
	with B or	급										of What Cor	untry ?	
	s 23	era	113 Eighth Stre	12. Was Deceden	t Ever in II S	2 12	21851	innania Odia	via2 (Casa			USA Race - Amer	ione ledice	
9	should be filed within 72 hours after death with the Maryland of Mental Hygiene. markad other then "natural", or Itams 23s or 28e-f show matic event, the Medical Everther must be notified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	Armed Forces	?		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	, Puerto R	lican, etc.)		Black, White		
5-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	:							whi	.te	
Ω.	"nat	Completed	15. Decedent's (Specify only highest			16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation du <i>ring m</i> ost	of working	g	16b. Kind	of Business/I	ndustry	
2	withir	d E	Elementary/Secondary (0-12)	College (1-4or	5+)			')			_			
N	filed v Hygie other t		12 17. Father's Name (First, Middle, L	act		Homer	naker	10 Matha	r'o Nomo	/Eint Middle	Dome			
anc	Duid be fi	Be	17. rathers Name (rirst, Middle, L	ast)						(First, Middle,	maiden Su	mame)		
Maryland 2121	should be nd Mental markad c	ဥ	Friedrich Goe						garet		Biber			
<u></u>	12 short and 7 Is m.		19a. Informant's Name/Relationshi				ng Address (Street a						ip Code)	
	s 1 and 2 should f Health and Mer itam 27 Is marks other traumatic		Heinrich Wehner 20a. Method of Disposition	(husbano			Eighth St.	., Po	COMOK Da	- 7			Farra Ctata	
altimore,			1 ☐ Surial 2 ☐ Cremation	3 □Removal from State	e ce	emetery, crei	natory or other place	1			20c. Locat	ion - City or 1	own, State	
<u>=</u>	tmen tent:		`4 □ Donation 5 □ Other (Sp.		Firs		ist Cemetery		/6/20		Pocom	oke Ci	ty, MD	
Ba	permit. Pages 1 a Department of Hes Importent: If itam eny injury or othe		21. Signature of Funeral Service L	Dean	7	I	Name and Addres Holloway 1 03 Linder	ss of Facility Melson n Ave	n Fun	eral H comoke	ome,	P.A. . MD 2	1851	
	- 111		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause	ed the death.	. Do not ent	er the mode of dying	g, such as	cardiac or	respiratory a	rest,		Approximate Interval Betw	een
	Pnysician i		Immediate Cause (Final disease or condition	DI	200	\mathcal{L}	ell C	0.00	in	omo	2		Onset and De	eath
	/Medical		resulting in death)	aDue to (or a	s a consequ	ence of):		u, c	-1. 1	0	_		7 mo	01.8
	Examiner		Convention list conditions	b										
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequ	ence of):						- 5		
	nd trans	Examiner	that initiated events	c										
Ö,	certificate be executed ding physician and ase as the burial-transit		resulting in death) Last	Due to (or as	s a consequ	ence of):								
3760	ate be ex hysician he burial	Ical		d										
9	ing ph	Med	IF FEMALE:											
Вох	eath certif attending for use as	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth			Ectopic pregnancy				23d	. Date of delin		ear
0.	Q 0 Q	sicl	1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown	at time of de	ath 5	Other (specify)					MOHIN	Day Ye	all late
<u>ч</u>	at the ded by the a	Phy	9 Unknown							00 5:4:				
Records,	The law requires that the tee has been signed by thoage 2 should be detache	by	Part II. Other significant condition	s contributing to death	but not resul	iting in the u	nderlying cause give	en in Part I.			obacco use /es 2 🗆 N		the cause of de bably 4 💆 Úr	
Ö	w require been sig should t	Completed								240 14600	22 12	4h Moss sut		lahia
ğ	hysiclan : The law his certificate has b I director, page 2 s	E D								24a. Was			opsy findings av ompletion of cau	
										1 ☐ Yes	2 X No	1 🗆 Yes	2 No	
Vital	or Attending Physician: ifter death. Director: After this certific in by the funeral director.	Be	25. Was case referred to medical examiner?	Hospital:			Othe	200		(Check only o	ne)			-
	Phys this al di	10	1 ☐ Yes 2 No 27. Manner of Death	1 □ Inpat		ER/Outpatier 28b. Time o	I 3 DOA	4 L Nur	rsing Hom	e Sd. Describe I		Other (Spec	ify)	
L C	ding h h. After funer	lo l	1 Natural 5 Pending	28a. Date of Inj (Month, D	ay Year)	Injury	Work	(?		od. Describe i	iow injury or	curred		
S	death.	ical	2 Accident investigation of Could not a could not be a could not b	ot be One Place of Is	niume At hos	ma fa et-		Yes 2□N	-	ontine /	Stroot and N	umbor or Pu	ral Davita Mombi	-0.5
Division of	or At	Certification:	4 - Homicide determin	building, e	etc. (Specify)	me, rarm, str)	eet, factory, office		20	City or Tov		umper or Hui	ral Route Numb	er,
	Hospitel		20a Continu	Dhusisian T. II. I										
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	of examinati	vieuge, deati ion and/or in	vestigation, in my op	ie, date and pinion, deat	h occurred	d at the time,	date and pla	u manner as : ice, and due	stated. to the cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifier	and maister's	arou.		29c. License	number			29d. Date si	igned (Month	, Day, Year)	
	⊬ 3 ⊢ ŏ		00 - 0	CI			111	420	111				2005	-
•			30. Name and address of person w	ho completed cause of	death (Itam	23a) (Type	Print)	101			- /	01-	~~~	- 00
8	ST 1		10/A MARIE		/ 1			10	7/	851				
	Sta	te	31. Date filed (Month, Day, Year)	32. Re si	trar's Signati	ure	110, 111	-10	XI	, , ,				
7	Registr	ar	APR 0	6 2005	eur.	K A	Ke M							

		For State Registrar	Sta	te of Ma	e of Maryland / Department of Health and Mental Certificate of Death							Hygiene 005 1333			331
Physicia /Medic		Decedent's Name (First, Mic DARI		F	REID		В	ROWN			2. Date of Dea Month APRIL	Day	Year 200		of Death
Examino Funeral Director	•	4a. Facility Name (If not instituted SAMAR 5. Social Security Number 191–36–8237		HOSP 7. Age	ITAU (In yrs. las		0.4	Town, or TIM 1 Year Days			8. Date of Birt (Month, Da 8-22		NA 9. B	ath irthplace (Stat	_
		Usual Residence of Decedent 10a. State 10b. Cour	nty			Town or Lo	cation				0-22	-40		10d. Inside	Pa.
death with the Maryland ms 23a or 28a-f show Li wat ben Liffed at	ector	Pa.	NA]	Philad									es 2 No
s 23a or 2	al Dir	10e. Street and 'umber 1939 N. Shars	wood Str	eet			10f. Zip	Code 1912	21			10g. Citi.	zen of What (USA	Country?	
1036 ours after deat ral', or itams ?	by Funeral Director	11. Marital Status 1 Never Married 2 M Widowed 4 Divorce	arried Am	s Decedent Evened Forces? Yes 2 Notes, Give ar or Dates:		1	Was Deced f Yes, spec		panic Ori , Mexican Specity:	gin? (Spec i, Puerto F	cify Yes or No- Rican, etc.)			nerican Indian, nite, etc. Black	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any injury or othar traumatic avant, Item after Item instruction.	Completed by		lent's Education hest grade comp	<i>leted)</i> lege (1-4or 5+			lent's Usua kind of wo DO NOT us omema	rk doné du se retired)	tion uring mos	t of workin	g		nd of Busines	s/Industry	
Maryland d 2 should be file th and Mental Hy it Is marked oth traumatic avent	To Be (17. Father's Name (First, Midd. Horace	le, Last) A	L	R	Reid				or's Name	(First, Middle,		Sumame) iddlet	on	
VIALY 12 shouth and M 7 is man	-	19a. Informant's Name/Relation Belinda McDu	nship (Type, Prir	nt)		19b. Mailin			nd Numbe	r or Rural	Route Numbe	r, City or	Town, State,	Zip Code)	
Baltimore, M6 permit. Pages 1 and 2. Department of Health as Important: If item 27 is any injury or othar trae		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 Remova	Daught from State	20b. Plac	213 ce of Disponetery, crem Peac	sition (Nan natory or o	ne of ther place	,		Philde	20c. Lo		r Town, State	121
Balti permit. Departm Importa any inju		21. Signature of Funeral Service) onne	2~		Name an	d Address	of Facilit	•	Balti 1101		, Md. North	21202 Ave.		
PALON, cate be executed / Medical Examiner and sthe burial-transit	dical Examiner	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b c	Ue to (or as a	consequen	nce of):								Interval E	d Death
The law requires that the death certific the has been signed by the attending bage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ❷ No 9 ☐ Unknown	10	es, outcome of Live birth 2 Pregnant at tir Unknown	☐ Fetal de	eath 3 🗆	Ectopic pro					2	3d. Date of de Month	elivery Day	Year
Lires that the signed by d be detac	d by Pr	Part II. Other significant cond		. 1	not resulti		derlying ca	ause giver	in Part I.			bacco us		to the cause o	f death?
	Completed by		KENT								24a. Was a autop perfor	in sy med?	24b. Were a prior to death?	autopsy finding	s available
The state of the s									ence 6		ecify)				
1							et, factory	, office		28	Bf. Location (S City or Tow		Number or F	Pural Route Nu	mber,
Hospi	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medic	ying Physicien: al Examiner: On and	To the best of the basis of e manner state	xaminatior	edge, death n and/or inv	occurred a estigation,	at the time in my opin	, date and nion, deat	place, ar h occurred	nd due to the c	ause(s) late and	and manner place, and d	tated.	(s)
To the within 2 To the complet	Me	29b. Signature and title of certif	. 0	N. C				. License i						th, Day, Year)	
I A	-		yelly)	MD	AL ():		f	15	300	3	RITAN	OL	1/12/	2005	•
State Registra	e :	30. Name and address of persons GLBERT BO 31. Date filed (Month, Day, Yea APR 2 0	DURJE		s Signatur	Lock	1 RA	JVE	UBI	LUD	BAL	TIM	ORE	MOZ	1239

State of Maryland / Department of Health and Mental Hygiene 1

13332

		Certificate of Death	Reg. No.
	Dhuninina	1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year 3. Time of Death
L.	Physician /Medical	Fannie G. Butler	4 17 2005 4:40 a.m
)	Examiner	4a Fecility Neme (If not institution, give street end number) 4b. City, To	own, or Location of Deeth 4c. County of Death
	٠	Future Care Bal	
	Funeral Director	219-22-5233 A 1 M 2 F 92 Yrs. Months Days Hours	724 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 9-22-1912 Va
	pud ≱	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Aaryle f sho		1 ☑ Yes 2 □ No
	vith the Mar or 28a-f sl be notified	10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?
	3a or		USA
	r thems 234	16.35 N. Payson Street 21217 11. Maritel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	igin? (Specify Yes or No- 14. Race - American Indian,
Maryland 21215-0020	Jrs e	If Yes, Give ↑ 1 ☐ Yes 2 ☐ No Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	
5-0	72 ho	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grede completed) (Give kind of work done during most	st of working
121	ed within 72 hor ygiene. For than "nature it, the Medical E	Elementary/Secondary (0-12) College (1-4or 5+) N/A Phone Wiring Tech	Western Electric
2			er's Name (First, Middle, Maiden Surname)
an	B S S S	Tr. Tanto a Mario (1 113), Micard, Easty	
<u></u>	d 2 should the and Ment 7 is marked treumatic		herine er or Rurel Route Number, City or Town, State, Zip Code)
Ma	2 0 0 0		: Unit 102 Gwynn Oak, Md 21207
ē,	ages 1 end into f Health if Item 27 or other tr	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Baltimore,	. Peges Iment of I bant: If ite jury or o	4 Donation 5 Other (Specify) King Memorial Park	4/22/05 Randallstown, Md
Ba	permit. Peg Department Important: eny injury o	21. Skraan Funeral Service Licensee 22. Name and Address of Facility 4300 Wash	w March F/H West eash Avenue Balto, Md 21215
	7	23a. Parh. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	
	Physician		Onset and Death
1	/Medical Examiner	Immediate Cause (Final disease or condition e. Encl Stage RENAL DISE resulting in death)	ASE Unknown
П		Due to (or as a consequence of):	
V	min ited	b. DIABETES MECLITUS	Unichewa
,	n end iel-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	
68760,	eath certificete be executed attending physician end for use as the bunel-transit claryMedical Examiner	that initiated events	Unknown
	ig phy es th	lesulting in death) Last	
ŏ	th cer endir r use	d. DEMENTIA	Unknown
П	he att	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	. 23b. Did tobacco use contribute to the cause of death?
<u>Ч</u>	es that the death ce igned by the attend be deteched for us by Physician/	Chronic Obstructive Rimonery Disease	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
S,	signer be d	Chronic Obstructive Minorery DiseasE	
ecord	The law requires that the death certificete be executed set hes been signed by the attending physician end page 2 should be deteched for use as the bunial-transit Completed by Physician/Medical Examir	ANEMIA	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
æ	The la		1 Yes 2 No 1 Yes 2 No
ita	entifice actor, Be C	25. Was case referred to medical examiner?	of Death (Check only one)
<u> </u>	Physician: r this certific arel director, n: To Be (ursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Division of Vital Records, P.O. Box	ath. w: After the funere funere ation:	27. Manner of Death 1 Anatural 5 Pending (Month, Day Year) 2 Accident investigation 28e. Dete of Injury 28b. Time of Injury 4 Work? 1 Yes 2	28d. Describe how injury occurred
Divis	is or Attending Pirs efter death. The Director: After to the in by the funers to certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The law within 24 hours effect death. To the Funeral Director: Affect this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date an Medical Examiner: On the basis of examination end/or investigation, in my opinion, dea and manner stated.	
	To the To the Comp	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		D. SALUJA MO DOO5905	6 4/17/05
	N		
_	1	DALJEET SALUJA , 1600 WEST MT D	OYGL AVE Balt., MD 21217
	State	31. Date filed (Month, Day, Year) 32. Registrer's Signature	OYGL AVE Balt., MD 21217
	Registrar	ALL VA CAL	

			1- State of Maryland / Department of Health Certificate of Deal			2005	13333
			Decedent's Name (First, Middle, Last)		2. Date of Death	g. Nos. UUU	3. Time of Death
	Physici		Dorothy Louise Laybourne Brickhouse		Month 04	Day Yea 18 200	ir N
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	on of Death	04	18 200 4c. County of De	
	Exami		Collington Episcopal Life Center Mitchelly	ille			George
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year		B. Date of Birth	9. 8	Birthplace (State or Foreign
	Director		498-01-0009 1 M 2X F 92 Yrs. Months Days Hour	rs Min.	04-17-1	91/3	Shio
	D ¥		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				
	sho	j	MD Prince George Mitchellville				10d. Inside City Limits 1 ☐ Yes 25 No
	the N	ect			10	- 0%	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Inportents if item 27 is marked other then "neturel", or items 23a or 28a-f show importents if item 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Evantian matter rottified at once.	Funeral Director	10. 2p coce	721	10	g. Citizen of What USA	Country?
	ms 2:	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	Origin? (Spec	ify Yes or No-	14. Race - Ar	merican Indian,
ထ	or Ital	교	Armed Forces? If Yes, specify Cuban, Mexi 1 □ Never Married 2 □ Married 1 □ Yes 3472No	ican, Puerto Ri	can, etc.)	Black, W	nite, etc.
21215-0036	rel', c	þ	3 ☐Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☐XNo Special S	cify:		Specify:	White
5-0	72 honetu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m.	nost of working	11	6b. Kind of Busines	ss/Industry
7	ithin nen "	n pk	Flementary/Secondary (0.12) College (1.4or 5+) life. DO NOT use retired)	node or monary	·	0 11	
2	led w tygier her ti		, Modeewile			Own Home	2
and	be fi	Be			First, Middle, Mi Nesbit	aiden Sumame)	
Maryland	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num			C/1 T C/1-1-	7.0.7
Ba	d2s than t7 Is I						, Zip Code)
ō,	1 an Heal tern 2		20a. Method of Disposition 20b. Place of Disposition (Name of	Da		10023 Dc. Location - City of	or Town, State
JO L	ages ant of it: If i		1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 1 □ Burial 2 □ Crematory or other place) 1 □ Chesapeake Crematory	V 0410	-2005	Beltsvil	
altimore,	artme orten injur		21. Signature of Funeyar Service Licensee 22. Name and Address of Far	, 07 13	-2005		
ä	Dep Imp		Rapp Funeral 933 Gist Ave	l & Cre	mation	Service	0
	20		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician `	7	Immediate Cause (Final disease or condition Stroke				Onset and Death
	/Medical		resulting in death) a. SETORE Due to (or as a consequence of):				1 month
	Examiner		Sequentially list conditions b				
	D #	ner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			-	
	ecute and trans	Examiner	that initiated events c.				
60,	cate be executed physician and the burial-transit	E E	Due to (or as a consequence of):				
8760		dical	d.				
×	ires that the death certifi signed by the attending d be detached for use a	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			20d Date of d	P
. Box	atten for u	cian	in the past 12 months?			23d. Date of d Month	Day Year
o.	y the d	ıysi	1 ☐ Yes 255No 9 ☐ Unknown 9 ☐ Unknown				
Δ.	The law requires that the tee has been signed by thoage 2 should be detache	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pal	ırt I.	23e. Did toba	cco use contribute	to the cause of death?
rds	quire; n sig uld be		Chronic Obstructive Pulmonary Diease		1 ☐ Yes	2 □ No 3 □ I	Probably 4 Munknown
S	sw requires been si	Completed			24a. Was an	24b. Were	autopsy findings available
Ä	The lav te has age 2	mo			autopsy	prior to death?	completion of cause of
ta		O	25. Was case referred to medical 26. Pla	ace of Death (1 ☐ Yes 2√ Check only one)	¥No 1LIY€	IS 2 NO
>	Physicien: this certificatal director,	To B	examiner?			ce 6 □Other (Sp	ecify)
0	ding Phy h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of lnjury at lnjury Work?		d. Describe how		
0	endii eath. or: A the fu	atle	2 Accident investigation M 1 Yes 2	□No			
Division of Vital Records,	or Atten ifter deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Stree City or Town,	et and Number or I State)	Rural Route Number,
	urs a urs a erel D			1			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, d and manner stated. □	and place, and death occurred	d due to the caus at the time, date	se(s) and manner a a and place, and du	as stated. ae to the cause(s)
	ithin ithin of the comple	Med	29b. Signature and title of certifier 29c. License numbe	9r	290	. Date signed (Mor	nth, Dev. Year)
	⊢ ≯ ⊢ ŏ		D0025079			04-18-200	,
	, n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	10		Don Yablonewitz 7404 Executive Place Lanham MD 2	20706 s	te 502		
	Sta	te	31. Date filed (Month. Day, Year) 32. Registrar's Signature				
	Registr	ar	APR 2 0 2005 Reserve de Sparke				

			1 - For State Registrar	State of	Marylar		artmen			and M		Reg. Ng. 0	5 13334
	Physic		Decedent's Name (First, Middle	,							2. Date of Dea Month	Day Y	3. Time of Death
	/Medi Examir		Margaret Bre	nner give street and numb	oer)		4b. City,	Town, or	Location of		April 1	4, 2005 4c. County of	2.00 a
			3126 Gracefiel		326				Sprin			Mont	gomery
	Funeral Director		5. Social Security Number 477-12-7068 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. 81	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day March	14, 1924	9. Birthplace (State or Foreign Country) Wadena, MN
	rytand how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	8e-f e	Director		gomery		Silver							1 ☐ Yes 2 ☐ No
	with ti	D	10e. Street and Number	11 5 1	11006		10f. Zip	Code 20904	<i>.</i>			10g. Citizen of Wh	•
	death me 23	Funerai	3126 Gracefi	12. Was Decede	ent Ever in U	.S. 13.				gin? (Spec	cify Yes or No- Rican, etc.)	United :	American Indian,
980	d within 72 hours after death with the Maryland Jone. Ir than "naturel", or Iteme 23e or 28e-f ehow The Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 🂢 Widowed 4 ☐ Divorced	Armed Force ed 1 Tes 2 If Yes, Give Year or Date	XNo	j	fYes,spec 1□Yes 2		n, Mexican Specify:	, Puerto F	Rican, etc.)	Black, Specify:	White, etc. White
21215-0036	72 hor	eted	15. Decedent' (Specify only highes	s Education		16a. Dece	ient's Usua kind of wor	I Occupa	ition	t of workin	10	16b. Kind of Busi	ness/Industry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	nt Ad	e retired,)		ig	Title 1	
d 2	H H		17. Father's Name (First, Middle, L	ast)		016	IIIL AG				(First, Middle,	Dept. of	f Education
<u>la</u> n	Aental Aental rked c	To Be	Albert Otto B	ecker								McCreery	y Becker
Maryland	nd 2 should be i lith and Mental I 27 le marked or r traumatic eve		19a. Informant's Name/Relationsh R. William Pow						nd Numbe	r or Rural	Route Numbe	r, City or Town, St.	ate, Zip Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Ie marked any injury or other traumatic et <u>QDCs.</u>		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sa		20b. F	Place of Dispo cemetery, crem lesapea	sition (Nam natory or ot ke Cr	e of her place emat	ory			20c. Location - Ci	ity or Town, State
3altii	permit. I Departm Importer any injur		21. Signature of Funeral Sepvice Licensee 22. Name and Address of Facility Rapp Funeral and Cremation										
	205 2		23a. Part1. Enter the disease, or			2 9	<u>33 Gi</u>	st A	ve.,	Sil _v	er Spr	ing, MD	20910
	Physician /Medical Examiner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Colo Due to (or b. Hepa	n line. n Canc as a conseq titis	er uence of):		, o, o, , , ,	, 30011 43		rospiratory arr	631,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq								
.O. Box 6	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		n 2∏Feta tattime of d	Joleath 3 □	Ectopic pre					23d. Date of Month	,
Q	sign sign d be	by	Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.				ute to the cause of death?
Vital Records,		Completed									24a. Was a autops perform	sy prio med? dea	re autopsy findings available in to completion of cause of th? It ?
Vita	Physicien: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital				0#			(Check only on	10)	
of	Attending Physic death. ector: After this obtto the funeral direction.	tlon: To	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation			ER/Outpatient 28b. Time of Injury		c. Injury Work	4 🗀 1901	28		ence 6 Other ((Specify)
Division	- 9	Certification;	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At ho etc. (Specif	ome, farm, stre	eet, factory,				9f. Location (St City or Town		or Rural Route Number,
	To the Hospitel o within 24 hours afr To the Funerel Di completely filled in	Medicai (29a. Certifier Certifying (Check only one) Medicel E	Physician: To the be xeminer: On the basis and manner	s of examina	wledge, death tion and/or inv	occurred a estigation,	t the time	e, date and inion, deatl	place, ar	nd due to the ca	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	Tot com	Σ	29b. Signature and title of certifier	Im Ha	Chelle	mD	1	License D236			2	9d. Date signed (A April 1	
	1.0		30. Name and address of person w		/ /			lver	Spri	ng, l	MD 209	10	
	Sta Registr		31. Date filed (Month, Day, Year)	APR 2 0 201	istrar's Sign	ture Manage	H. I	loss	وي				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12.23 PM 2005 Edward W. Backhaus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 15 M 2□ F Months Days Hours Yrs Director 87 216-07-1751 10/05/1917 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Baltimore Upper Falls 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a by Funerai 16 Gerwell Court 21156 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced "naturel" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is markad other then "r Elementary/Secondary (0-12) College (1-4or 5+) Automotive Garage Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Backhaus Mamie Naumann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai Diana Hughes /daughter 16 Gerwell Court Upper Falls, MD 21156 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 18 * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2005 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00986 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Unosepsis 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 2/C No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 2 Accident 5 Pending daath. 1 ☐ Yes 2 ☐ No after daath investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel C 29a, Certifier 1 🔀 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGELO JOSEPH #602 S-ATWOOD Rd \$205 BELASR MD 21014

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

20 2005 Keen Di Aprille

32. Registrar's Signature

RKD

Please Type or Print in Black Indelible Ink Engure All Conic

	State 1 - For Unpend Item 23a, 27, Registrar		artment of Health and I 1843 5-11-05 tas rtificate of Death	Mental Hygi	
Physician /Medica	Cachar	С.	Bruce	2. Date of Death Month APRIL	
Examine	4 = 10 +4 +4 +4 +1 +1 +1 +1 +1 +1 +1 +1 +1 +1 +1 +1 +1	number)	4b. City, Town, or Location of Deati	1	4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 6. Sex 215-85-1617	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Birthplace (State or Foreign Country) PA
death with the Maryland ms 23a or 28a-f ehow fraust be notified at	Usual Residence of Decedent 10a. State 10b. County Anne Arunde	10c. City, Town or Lo			10d. Inside City Limits 1 □ Yes χίχνο
after death with the Mainrithmes 23a or 28a-feindheir in uist be notified	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
ns 23a	6214 Flamingo Drive 11. Marital Status 12. Was De	ecedent Ever in U.S. 13.	21061 Was Decedent of Hispanic Origin? (S	necify Yes or No-	U . S . A
ors after all, or Ita	3 ☐ Widowed 4 ☐ Divorced If Yes, 0 Year or	Forces? s 2⊠No Bive	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White, etc. Specify: Black
hin 72 ha e. an "natu Medical	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	6b. Kind of Business/Industry
If Hygiene other the vent, the		Di	sabled 18 Mother's Nar	ne (First, Middle, Ma	Disabled
್ಷ ಕ್ಷ್ಮ ತ್ರಿ <u>ದ</u>	William Bruce		Shirley	Young	
nd 2 ilth a	19a. Informant's Name/Relationship (Type, Print) Victoria Bruce-Siste		ng Address <i>(Street and Number or Ru</i> 5th Ave, Arbut		City or Town, State, Zip Code) 21227
Pages 1 and inent of Health out: If item 27 iry or other tr	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer	natory or other place)		oc. Location - City or Town, State
permit. Pages 1 Department of H Important: If ite any injury or oth	21. Signature of Funeral Service Licensee	ŽÝ.	Zion 4/18 Rame and Addr To of Eacility Carch F/Th West 300 Wabash Ave		CONTRACTOR CONTRACTOR NO.
Physician	23a. Part1 Enter the disease, or complications that shoot or heart failure. List only one cause or immediate of use (Final	t caused the death. Do not ent each line.	er the mode of dying, such as cardiac		
/Medical Examiner	resulting in death) Due to	ine intoxication (or as a consequence of):	OII		
executad In and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Class of that that initiated events c.	o (or as a consequence of):			
te ba ysicia ie bui	d	o (or as a consequence of):			!
institutio death certificate be executed and detached for use as the burial-transit Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, o 1 ☐ Live 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
s been signad by the should be detach	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
)			24a. Was an autopsy performe 1 2 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
tending Physician: The Beath. Beath. Itor: Alter this certificate he the funeral director, page the funeral director.	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 ☐ Resident 28d. Describe how	injury accurred
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral di Medical Certification: To	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6X Could not be	05 ^{ay Year)} 6:30 ^{ry}	Work? 1 ☐ Yes 2 😿 No		unk
I o the hospital of Ar within 24 hours after of To the Funeral Direc completely filled in by Medical Certifi	TOUL	ding, etc. (Specify) id at home		Glen Bu	et and Number or five Rowe Number Dr. State) 6214 Flamingo Dr. Irnie, Maryland
in 24 hou in 24 hou he Fune pletely fil	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the and ma	ne best of my knowledge, death basis of examination and/or inv inner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
To the comp	29b. Signature and title of certifier	Y. /	29c. License number OCME		I. Date signed (Month, Day, Year) RIL 15,2005
	30. Name and address of person who completed car THEORONE Miking	use of death (II) m 23a) (Type.	Print) 111 Penn Stre		more, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) 32.	Redutrar's Signature	hade		

Jerry Sterl 05--02635 RPD

	ng	Bradshaw Ple	ease Type or Pr	int in Black	Indelible Ink	. Ensure A	II Copies	Are Legible		
635					epartment of H		-	_		
		1 - For State Registrer			Certificate of			g. No. 005	13337	
		1. Decedent's Name (First, Mic	ddle, Last)	-			2. Date of Deat	1	3. Time of Death	
Physici /Medi		JERRY	STERLI	NG B	RADSHAW		April 1	L4, 2005	1935 P ^M	
Examir		4a. Facility Name (If not institut		or)	4b. City, Town, o	or Location of Death		4c. County of Death		
		8831 Millard I	Long Road		Westove	er		Somerset		
Funeral		5. Social Security Number	6. Sex 7 1 □XM 2 □ F	Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) (Cor	place (State or Foreign intry)	
Director		212-56-1852	1 (2) W 2 (1) F	54 Yrs	3.		November 1	9, 1950 Viro	inia	
and w		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town o	r Location				10d. Inside City Limits	
Aaryi I sho	ō			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		- 1			1 ☐ Yes 2 ☒ No	
the A	Director	Maryland Wi	.comico			Hebron		200		
with	ā				10f. Zip Code		10	g. Citizen of What Cou	intry?	
eath	Funerai	7328 Levin Dashiell Road 21830 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							Sana India	
ter d Item	Ę	1 ☐ Never Married 2 ☐ M	Armed Force	s?	If Yes, specify Cubi	an, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet", or items 23a or 28a-1 show wenty injury or other traumatic event, the Madical Examiner must be notified at ODGe.	by	3 ☐ Widowed 4 ☒ Divorc	If Yes, Give	Specify: Wh	ite					
72 hc	sted	15. Deced	lent's Education hest grade completed)	16a. De	ecedent's Usual Occup Give kind of work done	pation	ing 1	6b. Kind of Business/Ir	ndustry	
ithin Ban Mac	Completed	Elementary/Secondary (0-12			e. DO NOT use retired	d)		Wicomico County		
ed w ygier yer th	Cor	12	5±	Sp€	ecial Educa		cher s	School Syst		
be fil tal H d ott	Be	17. Father's Name (First, Middle	•			18. Mother's Name	e (First, Middle, M	aiden Sumame)		
Men Men arke	J.	Rollins Tull	Bradshaw			Lucille H	Harper Br	adshaw		
2 sh and ls m		19a. Informant's Name/Relatio	onship (Type, Print)	19b. M	ailing Address (Street	and Number or Run	al Route Number,	City or Town, State, Zi	o Code)	
and ealth m 27		<u>Dennis Rollins</u>	Bradshaw (B	rother) 26	821 Robert			isbury, Ma	ryland 2180	
Jes 1		20a. Method of Disposition 1 ☒ Burial 2 ☐ Crematio	n 3 Removal from Stat	comoton:	sposition (Name of crematory or other place	ce) [Date 2	0c. Location - City or T	own, State	
men tant: jury		'4 □Donation 5 □ Other			e Memorial Pa	rk April	19, 2005 (risfield,	Maryland	
permit Depart Import eny in		21. Signature of Funeral Service	ce Licensee	1	22. Name and Addre				•	
<u></u>			Bradshaw-Pru		306 W. Mai	n Street	- Crisfi	eld, MD 21	817	
		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that caus ist only one cause on each	ed the death. Do not line.	enter the mode of dyin	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between	
Pnysician		Immediate Cause (Final disease or condition	m.	It. In	Taniunia				Onset and Death	
/Medical		resulting in death)	Due to (or a	s a consequence of):	- my or man					
Examiner		Sequentially list conditions,	b							
₽ #	aminer	if any, leading to immediate cause. Enter Underlying		s a consequence of):						
ecuted ind transit		that initiated events	С.							
ficate be exec physician an s the burial-tr	Ë	resulting in death) Last	Due to (or a	s a consequence of):						
ate b hysic the b	lica		d							
ing p e as	Med	IF FEMALE:			-					
eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetel death	3 ☐Ectopic pregnancy	,		23d. Date of deliver	,	
ne de the a hed f	Physician/Medical	1 Yes 2 No	4□Pregnant 9□Unknown	at time of death	5 Other (specify)			MOUTH	Day Year	
s that the death certificate be exe ned by the attending physician ar e detached for use as the buriat-t		Part II. Other significant condi	itions contributing to death	but not resulting in the	e underlying cause an	en in Part I	23e Did tobs	cco use contribute to t	he cause of death?	
S = 0	>	3				and the same to		and definition to to	Lados of additi:	

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner?

29a. Certifier

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed ierel Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after death. To the Funerel Director: After this

Division of Vital Records, P.O. Box 68760,

ompletely

Medical Certification: To Be Completed I 29b. Signature and title of certifier

1X Yes 2 No 27. Manner of Death 1 Natural
2 Accident
3 Suicide 4 - Homicide

(Check only one)

5 Pending investigation 6 Could not be determined

1 Inpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

woodwa

2 ER/Outpatient

28b. Time of

29c. License number OCME

3□ DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24a. Was an autopsy performed?

Yes

26. Place of Death (Check only one,

Other: 4 Nursing Home

1 ☐ Yes 2 No

111 Penn Street

2□ No

29d. Date signed (Month, Day, Year) April 15, 2005

Baltimore, Maryland 21201

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No

2 🗆 No

death (Item 23a) (Type, Print)

Mc King 182. Hegistrar's Signature 2 0 2005 31. Date filed Month,

Registrar DHMH 17 Rev 1/2001

			. For	State of Maryla				•		
	=		1 - State Registrar		Ce	rtificate of De	eath	Reg	3. No.2 0 0 5	13338
П	Physici	an	1. Decedent's Name (First, Middle, Last	•				Date of Death Month	Day Year	3. Time of Death
	/Media	cal	Emma Brow			4h City Tourn or la	nation of Doorb	April	10 200	
	Examir	ier	4a. Facility Name (If not institution, give Johns Hopkins			Baltimo			4c. County of Dea Baitin	
	Funeral		5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day,)		rthpface (State or Foreign ountry)
	Director		379-09-7009	M 2015	88 Yrs.	Months Days	Hours Min.	May 10,	1916	Virginia
	and w		Usuaf Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho	ō	Maryland Baltimo		Baltin					1 ☐ Yes 2 📆 No
	r 28a	Funeral Director	10e. Street and Number	/10	Darcin	10f. Zip Code		100	g. Citizen of What C	ountry?
	th with	alD	2716 Lodge Forest	Drive		21219			U.S.A	١.
	ems	ıner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Spe Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🗶 No If Yes, Give			Specify:	,,		White
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28e-f show disal Examinet much be notified at	edt	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usuaf Occupation	ın	16	6b. Kind of Business	/Industry
215	hin 72	plet	(Specify only highest grad	fe completed) Coflege (1-4or 5+)	(Give	kind of work done duri DO NOT use retired)	ng most of workir	ng '`	D. KING OF BUSINESS	unidustry
	filed within Hygiene. other than "	Completed	12			Homemaker			Own Ho	ome
nd	be file	Be	17. Father's Name (First, Middle, Last)			18	. Mother's Name	(First, Middle, Ma	uiden Sumame)	
<u>S</u>	should nd Men marke umatic	To T	Denzil Elwood Rus					/irginia		
Maryland	C1 60 70 60		19a. Informant's Name/Relationship (T)	•		ng Address (Street and				
ຜົ	1 and Health Iem 27 other tr		Jere V. Weber/Dat 20a. Method of Disposition		. Place of Dispo	sition (Name of			ore, Mary	rland, 21219
Baltimore,	permit. Pages Department of the Important: If ite any injury or of		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crer nion Cer	natory or other place)	04/14			le, Virginia
alt:	mit. F partme sortar r injur		21. Signature of Funeral Service Licens			. Name and Address of		/2003 LO		t Church Street
ä	Depa Impo any ir		F. Regan M	& Millian	Ke	eney and Basf	ford P.A.	Funeral Ho		ck, MD, 21701
,	1		23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the de						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	cecal co	ancer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
		10	Sequentially list conditions,	b. Due to (or as a cons	equence of):					
	nsit	nin	if any, leading to immediate cause. Enter Underlying	545 15 (5) 43 4 55/13	oquorios or,					
Ć	te be executed ysicien and te burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
760,	ate be executed hysicien and the burial-transit	cai		J						
89	The law requires that the death certifical tite has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:							
.О. Вох	ath ce ttendi	ian/l	23b. Was decedent pregnant in the past 12 moeths?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregnancy			23d. Date of del	livery Day Year
0	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	fdeath 5□	Other (specify)			WOITH	Day Teal
o,	that t	h h	Part II. Other significant conditions con	ntributing to death but not r	esulting in the ur	nderlying cause given in	n Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	w requires that been signed by should be det	d by						1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Junknown
O S	law rec as bee 2 shou	Completed						24a. Was an	24b. Were au	Itopsy findings available
Re	The la	ШО						autopsy	prior to death?	completion of cause of
Vital	ysician: The is certificate director, pag	Bec	25. Was case referred to medical			26	. Plac of Death	1 ☐ Yes 2 € Check on one)	No 1 ☐ Yes	2 9 NO
× ×	ys di	To	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3□ DOA Other:	4 Nursing Hom	ne 5 🗆 Residend	e 6 □Other (Spe	cify)
ŭ	ding Ph th. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	28c. Injury at Work?		8d. Describe how	injury occurred	
Division of	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	200 Bings of Injury At	home form str		2 No	9f Lagation (Ctor)	Annal Nombres of D	
<u>≥</u>		ertif	4 ☐ Homicide determined	28e. Pface of Injury - At building, etc. (Spec	cify)	вы, тастогу, опісь	2	City or Town, S	et and Number or Ru State)	Irai Houte Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in		29a. Certifier 1 Certifying Phys	sician: To the best of my ki	nowledge, death	occurred at the time, d	date and place, ar	nd due to the caus	se(s) and manner as	stated.
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my opinio	on, death occurre	d at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier			29c. License nu			Date signed (Monti	
	1		U/ h Mp			RES (oi	A	pr.110;	2005
1) ('		30. Name and address of person who co			Print)	altinoxi	o mo	0 10 211	
l	Ct		Joseffe River			Ave Bo	altinoxi	2 /20	4124	
es .	Sta Registra		APR 2 0 2005	2. Registrar's Sign	S. Space					

			_ For	State of Ma	ryland / Dep	artment of H	Health and N	•		B.
			1 - State Registrar		Ce	rtificate of	Death		Reg. No. 4 U L	5 13339
	Physicia	an	Decedent's Name (First, Middle, La.	it)				2. Date of Dea	Day Ye	
	/Medic	al	Thomas	A.	Br	OWN	or Location of Death	April	11 200 4c. County of E	15 1634
	Examin	er	4a. Facility Name (If not institution, given Anne Arundel Me		0.10					
	Funeral				(In yrs. last birthday	Annar	If Under 24 Hrs.	8. Date of Birt		Arundel Birthplace (State or Foreign Country)
	Director		216-34-3701 ¹ Usual Residence of Decedent	X o	87 Yrs.	Months Days	Hours Min.	Dec. 4,	y, Year) 1917 We	est Virginia
	ow =		10a. State 10b. County		10c. City, Town or L	ocation		- .		10d. Inside City Limits
	Mary Fe sh	ţo	MD Anne Aru	ınde1	Crowns	ville				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	23a (23a (23a (23a (23a (23a (23a (23a (alD	1140 Sunrise Bea	ch Road			032		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of If If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	- 14. Race - A Black, V	American Indian, Vhite, etc.
36	s afte	by Fu	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
ခု	within 72 hours after death with the Maryland sne.	edt	15. Decedent's Ed			edent's Usual Occup	pation		16b. Kind of Busin	ess/Industry
T.	n "na	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+	(Give	kind of work done DO NOT use retire	during most of world	king		,
21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is marked other than "natural", or items 23a or 28e-f show eumatic event, the Machel Examinat must be notified at	Completed	3	College (1°401 34		nal Sales	Manager		National	CirculatingCo
	be filed tal Hygid d other event, III	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
Maryland	should be ind Mental marked o umatic eve	To	Wyatt Simpson Br	:own			Della 1	Brown		
Jar	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic	, D	19a. Informant's Name/Relationship (er, City or Town, Sta	
	of Health Item 27 other tr		Imogene C. Brown	(Wife)				ad, Crow	nsville,	
0			20a. Method of Disposition 1			osition (Name of matory or other pla	I .			
Baltimore,			* 4 □ Donation 5 □ Other (Specifical Service Laborators)			t Cemeter 2. Name and Addre		5-2005	Annapoli	s, MD
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Liber	1299	2	Hardesty	Funeral			
			23a. Part1. Enter the disease, or com	plications that caused t	he death. Do not en				olis, MD	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line	t,	-				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to for as a	consequence of):	HIRA	+cree	ant ?		GRS
	Examiner									
	,	Jer	Sequentially list conditions, if any, leading to immediate ease. End underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	te be executed ysician and ie burial-transit	Examiner	that initiated events	C						
,092	e exe	EX	resulting in death) Last	Due to (or as a	consequence of):					
876	2 > 2	llcal		d						
89 x	eath certificate be exattending physician for use as the buria	Physiclan/Medl	IF FEMALE;	Ole If you systems a						
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of Month	Day Year
o.	that the de ad by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ille oi deatti - St	_ Ottlet (specify) _				
σ.	Physician: The law requires that the death certifica this certificate has been signed by the attending phy rail director, page 2 should be detached for use as the		Part II. Other significant conditions of	ontributing to death but	not resulting in the t	underlying cause gr	ven in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
Records,	quires n sign	Completed by						157	res 2 □ No 3 □	Probably 4 Unknown
Ö	s been signal	lete						24a. Was	an 24b. Wer	autopsy findings available
æ	The lav	E O							rmed2 deat	to completion of cause of h? Yes 2 No
Vital	ilcian: Th certificate rector, pag	a)	25. Was case referred to medical				26. Place of Dea			100 22110
>	Physician: this certific al director,	To B	examiner? 1 🗆 Yes 2 🗷 No	Hospital: 1 🗆 Inpatient	t 2 ER/Outpatie	nt 300A Ott	ner: 4 🗌 Nursing H	ome 5 ☐ Resid	dence 6 Other (Specify)
n of	ding Ph h. Alter th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of 28c. Inju Wo	ry at rk?	28d. Describe h	now injury occurred	
Sio	death. ctor: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not b				Yes 2□No			
Division	or Ati fter d Direct on by	Certification;	4 Homicide determined		y - At home, farm, st (Specify)	treet, factory, office		28f. Location (5 City or Tox	Street and Number o vn, State)	r Rural Route Number,
	Hospital or Attending 4 hours after death. Funerel Director: Alter tely filled in by the funer		29a. Certifier 1 Certifying Ph	nysician: To the best of	my knowledge, dea	th occurred at the ti	me, date and place	and due to the	cause(s) and manne	r as stated.
	To the Hospital or Attens within 24 hours after death To the Funeral Director: completely filled in by the	Medical		niner: On the basis of e and manner state	xamination and/or in					
	To ths within 2 To the complet	Σ	29b. Signature and title of certifier	110		29c. Licens			29d. Date signed (N	
0.	0	/	Mullen.	il		11 3	0 168		04-12	- 2003
	11/		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	Print)	(O) A.	1 solot	64-12 u, le	A 2 (600)
	11		31. Date filed (Month, Day, Year)	32. Registr	s Signature	Harle	To The	700		0 2 701
	Sta Registr		APR 5	0 2005	Select So	1				

			For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygien	4000 10040
	Physici /Medio	an	1. Decedent's Name (First, Middle, Las Nevgen	en Brown		04 0	3. Time of Death
<i>}</i>	Examir Funeral Director	er	4a. Fecility Name (If not institution, give MeVay Med (C 5. Social Security Number 6. S	al Center	4b. City, Town, or Location of Deat Boutmure iMa If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Ball hwive 9. Birthplace (State or Foreign Country) 2005 Mary and
	ō		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits
	vith the Ma	Director	10e, Street and Number	BAltin	10f. Zip Code	10g. C	1 X Yes 2 □ No Citizen of What Country?
36	72 hours after death with the Maryland natural', or Items 23s or 28s-1 ehow ites! Examinations be notified at	Completed by Funeral Director	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	l within 72 hou iene. r than "natura tra Medical E	ompieted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)		Kind of Business/Industry
Maryland	ould be filed Mental Hyg arked other atic avent,	To Be C	17. Father's Name (First, Middle, Last)	BROW	N 5+0	me (First, Middle, Maide M	LYNN
nore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avent, Ita Medical Examination in Italian at Angles.		19a. Informant's Name/Relationship (WAYNE BROWN 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specification of the control of the con	FATHER 650 Compared to the compared to the	ematory or other place)	AN STRE Date 20c.	
Baltimore,	permit. P Departme Importan any Injur.		21. Signature of Funeral Service Licer	ISAO :	22. Name and Address of Facility Sterling Ashton S 736 Edmondson Ave		
	Physician // Medical bubbician and physician and physician and state in the partial-transit	Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, seading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the death. Do not en	nter the mode of dying, such as cardia		Approximate Interval Between Onset and Death Our Lami
.O. Box 68760	death certifi e attending ed for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
۵.	quires that the n signed by th uld be detache	by	Part II. Other significant conditions of	contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
l Records,	The law requires ate has been sign page 2 should be	Completed				24a. Was an autopsy performed?	
ion of Vital	Attending Physician: The death. ector: After this certificate by the funeral director. pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Avatural 5 Pending 2 Accident investigatio	Hospital: 1 Inpatient 2 ER/Outpati 28a. ate 1 Injury (Month, Day Year) 1	ent 3 DOA Other: 4 Nursing I	ath (Check only one) Home 5 Residence 28d. Describe how in	
Division	ire ire	Certification:	3 Suicide 6 Could not be determined		street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel of within 24 hours at To the Funerel is completely filled in	edical	(Check only 2 Medical Examone)	nysician: To the best of my knowledge, deaniner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, date a	and place, and due to the cause(s)
)	To t To t	×	29b. Signature and title of certifier	alshan Der	29c. License number 14372	29d. C	Otto Signed (Month, Day, Year) OH O8 2005
	Sta	ate	31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (Typic Strangers of Term 32. Registrar's Signature,	1, 22 South (siveene Sh	reet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

			1- State Amend Item		tem 23a	Weba Wer	irtment of F	lealth and Death			<u>2005</u>	13341
	Physic /Medi		1. Decedent's Name (First, Middle, L SYDNEY M. I	BROWN					2. Date of D Month April	Di	ay Year 2005	3. Time of Death 7:25 A
	Examir		4a. Facility Name (If not institution, gi)		4b. City, Town, or			4	c. County of Death	1
2	Funeral			Sex 7. A	ge (In yrs. last i		Randallst	If Under 24 Hr		irth	altimore	
7	Director		219-71-4335 Usual Residence of Decedent	1□ M 2 X F		Yrs.	Months Days	Hours Mir	03/11	$\frac{2}{20}$	05 Mar	place (State or Foreign intry) yland
	yland how		10a. State 10b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits
	ith the Marylan or 28a-f show	ector	Md Baltin	ore	Owing	gs M						XZYes 2 □ No
	death with the Maryland ms 23a or 28a-f show	Dir	10e. Street and Number 9309 Owings Ch	oice Con	rt		10f. Zip Code 21117			_	itizen of Whal Cou JSA	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours attar death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is markad othar than "natural", or items 23a or 28a-1 show any injury or othar traumatic event, It e Medical Examinational to infilted at once.	by Funeral Director	11. Marital Status 2☐ Married 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S.	1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No		Specify Yes or N rto Rican, etc.)		14. Race - Amer Black, White Specify: B1	, etc.
215-0036	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16	a. Deced	ent's Usual Occupa kind of work done of O NOT use retired	ation during most of wo	orking	16b. F	Kind of Business/Ir	ndustry
7	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than any injury or other traumatic event, ILE MODE.	Somp	Elementary/Secondary (0-12)	College (1-4or		nfa		,		I	nfant	
Maryland	d be file ntal Hy ad oth	Be	17. Father's Name (First, Middle, Las Orlando Brown)					me (First, Middle		n Sumame)	
ary	should be tnd Mental s markad c umatic eve	Ţ	19a. Informant's Name/Relationship	Type, Print)	19	9b. Mailing			ss Port		or Town, State, Zii	Code) 21117
	l and 2 lealth a m 27 la		Sherress Porter	- Mothe	er 93	309	Owings	Choice	Court			
nore	ages 1 int of H t: If ita y or ot		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □		1		ition (Name of atory or other place	1	Date		ocation - City or T	
Baltimore,	mit. P partme portan y injury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	1 1			Cemetar Name and Addres					,Md.
8	perm Depa Impo any is		23a. Part1. Enter the disease, or conshock, or heart failure. List only	(u as	Cop	Es Ba	tep Bro ltimore	thers Mary	Funera, land	$^{\mathrm{l}}_{212}$	rvice [7	
A	Prrysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pneumoni		licat	r the mode of dying		c or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	a consequence							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C.	a consequence	5 01).						
68760,	B be axecuted sician and burial-transit		resulting in death) Last	Due to (or as	a consequence	e of):						
	rtificata ng physi as the b	Medical	IF FEMALE:	0								
.O. Box	iaw requires that the death certificata be axecuted as been signad by the attending physician and 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)				23d. Date of delive Month	ery D <i>a</i> y Year
Records, P	w requires that been signad I should be det	by	Part II. Other significant conditions	ontributing to death b	ut not resulting	in the und	derlying cause give	n in Part I.				ne cause of death?
al Rec	Tha ate hi	Completed							24a. Was autor perfo 1 🗷 Yes	osy ormed?	death?	psy findings available mpletion of cause of 2 No
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Division of	Attanding Phir death. actor: Aftar thi	Certification; T	27. Manner of Death 1 The Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	7.2	Time of Injury	28c. Injury Work		28d. Describe I			<i>n</i>
Divis	ol or Att	ertific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury - At home, f c. <i>(Specify)</i>	arm, stree	et, factory, office		28f. Location (S City or Tox	Street an vn, State	d Number or Rura)	l Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Example	ysician: To the best niner: On the basis of and manner sta	examination a	e, death ond/or inve	occurred at the time stigation, in my opi	e, date and place inion, death occu	, and due to the irred at the time,	cause(s) date and	and manner as st I place, and due to	ated. the cause(s)
	To T com	Σ	29b. Signature and title of certifier	en 1	10-		29c. License				te signed (Month, l	
C	10/1	>	30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Pr				vafor 1	L. L. J. 20	
1	Hen i		ZABIUCEA	H H	6			enn Stre	et Bal	timo	re, Mary	land 21201
3	Sta Registra		31. Date filed (Month, Day, Year)		S Signature	J.S.	GOBESS !					

COPES		- For Unpend Item 2 Registrar	State of Maryl 3a&27 per me	and / Dep C843 Ce	artment of I 11-05 ta rtificate of	Health and Death	Mental Hy	/giene Reg. No?	5 13343
Physician	,	1. Decedent's Name (First, Middle, Las	t)				2. Date of D Month		3. Time of Death
/Medical	1	Kim Copes					APRIL	16, 2005	0814 A
Examine		4a. Facility Name (If not institution, give MARYLAND GENERAL	HOSPITAL		BALTI	or Location of Dea	Ý	4c. County of [Death
Funeral Director		5. Social Security Number 6. Social Security Number 1 220-76-2975 Usual Residence of Decedent	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days				Birthplace (State or Forei Country) aryland
land ow	-	10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limi
Man,		Maryland		Balti	more				1 ∑Yes 2 □ N
with the Marylar sor 28e-f show) i e	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
ath w		4321 Cedar Garden	Road		2122			U.S.A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, If a Medical Exactifier must be neitified at once. To Be Completed by Funeral Director	ny rune	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 █️XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🟋 No		Specify Yes or N rto Rican, etc.)		American Indian, Vhite, etc. Black
led within 72 hor ygiene. ner than "natura it, Ira Madical E	bielen	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Busine	ess/Industry
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d 2 should be filed within 72 hours aft this and Mental Hygiens 17 is marked other than "natural; or traumatic evant, in a Medical Exami To Be Completed by F	מ	17. Father's Name (First, Middle, Last)						e, Maiden Sumame)	
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f and 2 st fealth and im 27 is n her traun		19a. Informant's Name/Relationship (7 Camesha Copes / Da	ughter	4321 (Cedar Gar		Baltimo	ов, City or Town, State ore, Maryl	and 21229
ages nt of h	1	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	-	natory or other pla	· i	Date	20c. Location - City	
permit. Pages 1 ar Bepartment of Hea mportant: If itam iny injury or other	1	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 			Cemetery	04/2	23/2005	Landsdown	e, Maryland
permit. Departr Imports any inj		2t-11		46	ll Park	Hgts. Av	e., Balı	imore, Ma	F/H, P.A. ryland 2121
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the done cause on each line. End Stage R			ng, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
Je Je	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	sequence of);					
icate be executed physician and the burial-transit call call Exami	201	that initiated events resulting in death) Last	Due to (or as a cons	sequence of);					
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as completed by Physiclan/Mecompleted by Physiclan/Mec		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No 9N☑ Unknown	23c. If yes, outcome of pre- 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	delivery Day Year
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ician: Sertific ector.		25. Was case referred to medical examiner?	to a shall				ath (Check only o	one)	
T I di		27. Manner of Death 1 X Natural 5 Pending	fospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Wor	y at k?		dence 6 Other (S	pecify)
or Attan fter deat Diractor; in by the		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, streetly)		Yes 2 No	28f. Location (Street and Number or vn, State)	Rural Route Number,
To the Hospital or within 24 hours after to the Funeral Discompletely filled in Medical Cert		29a. Certifier (Check only one) 1 Certifying Phy 2 Madical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	knowledge, death ination and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	a, and due to the surred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
Y To the Comp		9b. Signature and title of certifier	re Thele	W	29c. Licenso	e number		29d. Date signed (Mo APRIL	nth, Day, Year) 16, 2005
DENI) A		MANGARUTO P.1	ompleted cause of death (It	tem 23a) (Type, F		Penn Stre	eet Bal	timore, Ma	ryland 2120
State Registrar		31. Date filed (Month, Day, Year) APR 2	32. Registrar Sig	gnature	parte	è			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 04 **Physician** 13 2005 Dorothy W. Collins 12:45pM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Himalayan Elderly Care Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 11-14-1920 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 84 Months Days Hours Min. 081-16-0571 1 ☐ M 2 🖾 F Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic evant, it e Medical Examiner over be notified at 1 XYes 2 No Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Itams 23a or 17234 New Hampshire Ave 20905 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. sm 27 Is marked other then "netural", or Ita 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify.Black þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) Be Charles Washington Lottie Banks ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milly Spector/POA 817 E. Franklin Ave Silver Spring MD 20910 itam 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. 1 ☐ Burial 2©Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville MD 04-20-2005 ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rapp Funeral $^{\&}$ Cremation Services M00382 Kut Johnnann 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 years Alzheimer's Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 No 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 Yes 2 No ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Accident Infury ospitar -4 hours after dec. - ral Diractor: After 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 04-19-2005 D09834 di Oreabaun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Barry Rosenbaum 3720 Farragut Ave Kensington MD 20895 parte Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death L1 . Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** 18:20 April William W. Carpenter, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Millersville 578 Hamella Court If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 15 M 2 ☐ F Director 458-01-4081 85 Dec. 16,1919 Texas Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exactinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with USA Funerai 578 Hamella Court death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify λq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) N.S.A. Computer Analyst 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clotee Stovall Thomas Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 578 Hamella Court; Millersville, Maryland 21108 Merlaine B. Carpenter Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Balto.Wash.Crematory | 4/19/2005 Laurel, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 21. Signature of funeral Service Licensee M01290 23a. Part1. Enter the Part 1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIN /Medical Due to (or as a consequence of) CAUDIOVASCULAR **Examiner** MITERIOSCLERETIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 19, 2005 D21776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURYA 8021 RIZCHIE HWY 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

Horace Dismond

Baltimore, Maryland 21215-0036

		Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and	•	•	
		1- State of Maryland / Department of Fleath and Certificate of Death		. No 2 0 0 5	13345
Physic /Medi		1. Decedent's Name (First, Middle, Last) HORACE MARSHALL DISMOND	2. Date of Death Month	14 ZOO	
Examir Funeral Director	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec BOOD SAMARITAN HISPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Min Months Days Hours Min	s 8. Date of Birth	4c. County of Dea 9. Bir	th thplace (State or Foreign synty) KGINIA
72 hours after death with the maryland historiel, or frems 23e or 28a-1 show digal Examinat must be notified at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ADD 10c. City, Town or Location			10d. Inside City Limits
23e or 28a- ust be notif	i Director	10e. Street and Number 426 WINSTON AVE. 10f. Zip Code 21212	109	g. Citizen of What Co	ountry?
el', or Items 23e Examiner must	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armod Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armod Forces? 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	prican Indian, te, etc.
Hygiene. ther then "naturel", int, It's Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College 1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) DIRECTUR	rorking	6b. Kind of Business	Andustry BATIMORE
D A	To Be Co	17. Father's Name (First, Middle, Last)	ame (First, Middle, Ma		'E
7 le trau		19a. Informant's Name/Relationship (Type, Print) HORACE DISMOND, JR. ISON 424 UINSTON 1	Aural Route Number,	City or Town, State,	Zip Code) 21212
Department of Healt Importent: If item 2 any Injury or other: QDCE.		20a. Method of Disposition 1		Oc. Location - City or WINGS M GREENE My	ILLS, MARYLA FUNERAL TO 1212
/sician ledical aminer		23a. Part 1. Enter the disease, or demplications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Evaluation as a consequence of):	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
and I-transit	ical Examiner				
ned by the attending physician detached for use as the buria	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown		23d. Date of de Month	livery Day Year
50.00	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus			o the cause of death?
page 2 should t	Complete	Itypertension	24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 No
r death, octor: After this certificate by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Home 5 Residen 28d. Describe how 28f. Location (Stre	ice 6 Other (Spe vinjury occurred set and Number or R	
within 24 hours after death. To the Funerel Director: After this cartifics completely filled in by the funeral director, p	sal Certi	4 Homicide building, etc. (Specify) 29a. Certifier (Check only (Check only and plate of the country of the basis of examination and/or investigation, in my opinion, death oc	City or Town,	use(s) and manner a	s stated.
within 24 To the Fo complete	Medical		296	d. Date signed (Mon	
Vo		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			2005
St	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZEIGLEM MAKONNEN 5601 Loch Raven Blvd, 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1201+1m0	re, IVID	21234
Regist	9	APR 2 0 ZUUD - Karak B A			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Year SAMUEL DIGGS :12 P.4M 13 04 /Medical 2005 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE If Under 1 Year | If Under 24 Hrs. | Hours | Min. Date of Birth (Month, Day, 9. Birtholace (State or Foreign **Funeral** 213.28.7147 Director Usual Residence of Decedent with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene.
Important: If item 27 is merked other than "neturel", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Exanthar must be neithed at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits BATIMORE 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 21223 Was Decedent Ever in U.S. Amed Forces?
1 Yes 2 W No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PASTEURIZEK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be D1665 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, ELLA ۷. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 DBurial 2 Cremation BATIMORE, MARYLAND PARK CEMETERY 4.19.05 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAWAHN C. GALENE ENERNY Home PACTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or coshock, or heart failure. List only plications that caused the death. Do not enter the Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Records, P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COPD 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed Memery certificate 20 Division of Vital 1 Yes 25. Was case referred e medical examiner? To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 1 1 1 1 0 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 🗌 Yes 2 No Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) APRIL 18 2005 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Eulaw A. AHMED 57 31. Date filed (Month, Day, Year) APR 2 0 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day APRIL 11 2005 **Physician** DUDDERAR C 8.51 a RICHARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral **X** M 2□ F **1**932 73 Maryland Director 218-36-1221 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Frederick Frederick Maryland Director 10e. Street and Number 10f. Zin Code 10g Citizen of What Country? 7988 Quay Court 21701 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Dairy Farmer Farming Pagas 1 and 2 should ba filed vent of Health and Mental Hygie ant: If Item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clifton Peter Dudderar Mary Baker ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7988 Quay Court, Frederick, MD 21701 Janet S. Dudderar, wife other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ŏ Linganore Cemetery permit. Page Department of Important: If April 14, 2005 Unionville, MD * 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service License 22. Name and Address of Facility
Keeney and Basford PA Funeral Home Kichery) M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Das Myogardia cute Interction /Medical Due to (or as a consequence or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate ba executad burial-transil Due to (or as a consequence of): the attending physician Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No or Attending Physician: completely filled in by the funeral director, Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No al Diractor: / death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 I Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HISON IND who completed cause of death (Item 23a) (Type, Print

Registrar

0 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		•	For State Registrar	State of	Marylan		artmen rtificate			and M		gien Reg. N	61115	13348	3
			Decedent's Name (First, Middle)	, Last)							2. Date of De		ay Year	3. Time of Death	_
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Medical Exantrate must be notified at 200e.		Edward Dew/ Bro 20a. Method of Disposition	tner	20b. F	lace of Dispo	hingt osition (Name	ne of		_2001	ate	20c.	Location - City or T	own, State	_
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	aminer	4a.	Facility Name (If not institution,		·)			or Location of I				ty of Death	
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/Med		Vivian Elizabeth					April	14	2005	0715 M
Exami	iner	4a. Fecility Name (If not institution,				or Location of Death			ounty of Death	
Funeral		Upper Chesapea	6. Sex 7. Age	enter (In yrs. last birthday)	Bel Air	If Under 24 Hrs.	8. Date of Bir	h	rford 9. Birthp	place (State or Foreign
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of Hear itam r othe		20a. Method of Disposition		20b. Place of Dispo			Date		tion - City or To	own, State
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iing Physician: The law requires that the death certific. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown Is contributing to death but 1 Death	of pregnancy 2 Fetal death 3 ime of death 5 ime of death 6 ime of	DEctopic pregnancy Other (specify) Inderlying cause give Inderlyin	yen in Part I. 26. Place of Deather: 4 \(\text{Nursing Ho} \) yat k? Yes 2 \(\text{No} \) me, date and place.	24a. Was autop performent of the control of the con	obacco use Yes 2 1 an 2 sy med? 2 1 July 1 July 2	Month contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to the contrib	psy findings ampletion of cause of display 4 PU psy findings ampletion of cause (s) No

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	larylan		artmen tificate				R	eg. No.	2005	133	51
A STATE OF THE STA	Physici /Medi Examir	al	Decedent's Name (First, Middle, La Mary 4a. Fecility Name (If not institution, gin	Α	·)	Eber		Town, or	Location of	Ap	Date of Dear Month oril	1 2 Day	, 2005		
X p	Funeral Director		837 South Mont 5. Social Security Number 6. S 213-03-1712			last birthday) Yrs.	If Under Months		imore If Under 2	4 Hrs. g	Date of Birth (Month, Day, or 27,		n/a	nplace (State or untry) yland	Foreign
4	ט	ctor	Usual Residence of Decedent 10a. State 10b. County	/a		y, Town or Lo	cation	re		Ap	ΣΖ/,.	191	o Mar	y Land 10d. Inside City 1 XYes	Limits
9	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. It marked other than "haturel", or litems 23a or 28a-f show other traumatic event, the Madical Examiner must be nutilised at	Funeral Director	10e. Street and Number 837 South Mont 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married	12. Was Deceden Armed Forces 1 \(\text{Yes} \) 2 \(\text{Y}	t Ever in U.			21 lent of Hi rfy Cubar		in? (Specify Puerto Rica			US US 4. Race - Ame Black, White	A rican Indian,	
Maryland 21215-0036	within 72 hours and.	Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)			16a. Deced (Give life. L	kind of wor OO NOT us	l Occupa k done d e retired,	ition luring most o	of working		16b. Kir	nd of Business/	·	
ryland 2	should be filed and Mental Hygis marked other	To Be Co	6th 17. Father's Name (First, Middle, Last Samuel Lejk 19a. Informant's Name/Relationship (me M		18. Mother	nna B	rst, Middle, M	e k	Own H Sumame) Town, State, 2		
a)	Pages 1 and 2 sho nent of Health and int: If item 27 is m iry or other traum		Mary Grubowski 20a. Method of Disposition 1 Burial 2	(daught	20b. P	960 F Place of Disposemetery, crem	'e11 sition (Nam natory or oi	Str ne of ther place	eet l	Unit Date	406 H	3a1 1 20c. Loi	timore cation - City or	, Md21	
Baltii	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	ansee		²² 25	Name and 25 F	d Addres	s of Facility t Str	Kaczo reet	rowsk Balti	i l imo	Funera	Home 21224	
27	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	ine.	-	_		NELL.					Interval Betwee	ath
8760,	certificate be executed ding physician and use as the burial-transit	dicai Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a:	mi		Fi B.	ell	れづる	^				yni	
ă.	death e atter ed for u	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre					2	3d. Date of deli Month	very Day Ye	ar
-	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	contributing to death	but not resu	ulting in the un	iderlying ca	luse give	n in Part I.					the cause of dea	
Ť	The ate h page	e Completed	25. Was case referred to medical						26 Place o		24a. Was ar autopsy perform 1 Yes 2	ned? (XNo	prior to c death?	opsy findings av ompletion of cau 2 \(\text{No} \)	ailable se of
vision of	Attanding Phys r death. actor: After this by the funeral di	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatio 3 Suicide 6 Could not be determined	e 28e. Place of In	ury ay Year) njury - At ho	ER/Outpatient 28b. Time of Injury	M 28	3c. Injury Work 1 🗆 Y	r: 4 ☐ Nurs	28d.	5 🔀 Resider Describe hor Location (Str	nce 6 w injury		ify) ral Route Numbe	эг,
	Hospita 4 hours Funara (ely fille	edical Cert	29a. Certifier 1 Certifying Ph	ysician: To the best	of examinat	wtedge, death	occurred a	it the time	e, date and inion, death	place, and o	City or Town, due to the ca t the time, da	use(s) a	and manner as place, and due	stated. to the cause(s)	- 1
	To the within 2 To tha Complet	Mec	29b. Signature and title of Cartifler					License D 2	number 4276				signed (Month		
	Sta Registr	te	30. Name and address of person who Simon V. Scali 31. Date filed (Menth. Day, Year) A 1 2 0 2005	a, M.D.	2801 rar's Signat	Huds	on S	tre	et Ba	altim	ore,	Mar	yland	21224	

FREDERICK GERALDINE

			Please T	ype or Print in Black	Indelible Ink. Ensure A	II Copies Ar	e Legible.
			_ For	State of Maryland / D	epartment of Health and N	_	
			State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg.	No. 3. Time of Death
	Physici		DERALDINE	MICHELLE	FREDERICK		Day Year 5.50 A M
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death
100	Tables.		5. Social Security Number 6. Sex		BALTIMORE day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		218.40.5277 10		rs. Months Days Hours Min.	OCTOBER	18,453 MARYLAND
	yland Iow		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	8a-f at	Director	MD	DAC	TIMORE		1 V Yes 2 No
	with the	i Dire	1815 E. CHA	SE St	10f. Zip Code	10g.	Citizen of What Country?
	ems 2:	Funerai		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Quban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-f ahow or other traumatic event, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 ♥No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	,	Specify: BLACK
2	72 hou		15. Decedent's Educ (Specify only highest grade	completed)	Decedent's Usual Occupation Give kind of work done during most of work	ing 16b	. Kind of Business/Industry
121	filed within 72 Hygiene. other than "nal	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired) IFAC HFL		SCHOOL
ام 2	e filed Il Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	VWK	18. Mother's Nam	e (First, Middle, Maic	den Surname)
Maryland	should be and Mental marked o	ToE				SSIE H	REDERICK
Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Ty)	PICK SISTER 18	Mailing Address (Street and Number or Rui	al Houte Number, Cit	ny or Town, State, Zip Code) MO 2/2/3
ore,	of Health of Health litem 27 r other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	cometen	Disposition (Name of crematory or other place)	Date 20c	Location - City or Town, State
timore,	Z r e		*4 ☐ Donation 5 ☐ Other (Specify)	MARYLAN	O NATIONAL 4.2	2.05 LA	VKEL, MARYLAND
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service License	N. Stra	22 Name and Address of Facility WA	BATIM	ARE MAN 21212
ř-			23a. Part1. Enter the disease, or contp.	cations that caused the death. Do no	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	SEPSIS			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		
	*	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):		
	acuted ind transit	aminer	cause. Enter Underlying Cause (Listance or Injury that initiated events resulting in death) I ast				
60,	The law requires that the death certificate be exeate has been signed by the attending physician are page 2 should be detached for use as the burial-	ai Ex	resulting in death) Last	Due to (or as a consequence of):		
68760,	tificate ig phys as the	Completed by Physician/Medical		-			
Вох	ath cer ttendin or use	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O.	that the death led by the atter detached for u	iysic	1 ☐ Yes ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		
o, O	ss that gned b	by Pt	Part II. Other significant conditions con				co use contribute to the cause of death?
ord	w requires that been signed t should be det	ted	CEREBRO VASCU	LAR ACCIDE	NI	1 🗆 Yes	2 No 3 Probably 4 Onknown
Vital Records,	has b	mple				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ta	ician: The li certificate ha rector, page 3	Be Co	25. Was case referred to medical		26. Place of Dea	th (Check only one)	No 1 1 Yes 2 No
	Phyaician: this certific al director,	To B	examiner?	ospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nursing Ho		6 ☐Other (Specify)
Division of	ting After funer	tion:	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury 28b. Ti		28d. Describe how in	
VISI	or Attendate death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fan building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number,
ō	urs afte		(2)				
	To the Hospitel or Ati within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier Certifying Phys (Check only 2 Medical Examir one)	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	10	29c. License number		Date signed (Month, Day, Year)
)	1		1 6 Bayyer	ly, M.D	P15306	4	116105

Registrar DHMH 17 Rev 1/2001 GIBERT BOURJEILY

31. Date filed (Month, Day, Year) APR 2 0 2005

30. Name and address Tersof who completed cause of death (Item 23a) (Type, Print) GOOD SAHARITAN HOSPITAL GUBERT BOURJEILY, 5601 LOCH RAVEN BLVD, BALTIMORE, MDZ1Z39

31. Date filed (Month, Day, Year)

APR 2, 0, 2005

			1 - For State Registrar	State of N	faryland / De C	partment of <i>ertificate o</i>		d Mental Hy	ygiene	05	13353	3
	Physic /Medi		1. Decedent's Name (First, Middle, Li Phyliss L. Fral					2. Date of D Month 04	eath Dav	2005	3. Time of Death	_ 1
	Exami		4a. Facility Name (If not institution, git 10214 Royal Rd.			Silve	or Location of De		4c. Cour	nty of Death		~~
	Funeral Director		-	Sex 7. A 1 □ M 2 🔀 F	ige (In yrs. last birthda 61 yrs.	Months Day		in. 8. Date of Bi (Month, D 01-28	irth 8-1944	COU	place (State or Foreignty) ington DC	n
	the Maryland 28a-f show notified at	Director	10a. State 10b. County MD Montgo 10e. Street and Number		10c. City, Town or Silver				10- 0		0d. Inside City Limits MXYes 2 □ No	
9036	within 72 hours after death with the Maryland sne. than "natural", or Items 23a or 28a-f show III Medical Exam not marker politibed at	by Funeral	10214 Royal Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Tovorced	12. Was Deceder Armed Forces 1 _Yes 2 f If Yes, Give Year or Dates	i?] No	3. Was Decedent of If Yes, specify Cu	20904 Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ace - Americ lack, White, hify: Whi	ean Indian, etc.	
Maryland 21215-0036	thin 6.	e Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Lasi	ade completed) College (1-40)	(Gi	cedent's Usual Occ ve kind of work don . DO NOT use retii	e during most of w	vorking lame (First, Middle		auran		_
arylan	es 1 and 2 should be filed wi of Health and Mental Hygien If item 27 is marked other th ir other traumatic avent, Illa	To Be	Alvin Stultz Fra		19b. Ma	iling Address (Stree	Rose1	la Pearl	Snyder		Code)	_
altimore, M	Pages 1 and 2 nent of Health a ant: if item 27 is ury or other trau	1000	Shannon Ott (20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specia	SOn) Removal from State (y)	901 20b. Place of Dis cemetery, cr	McNeil L position (Name of ematory or other pl ake Crema	n, Silve	r Spring	MD 209	05	wn, State	_
Balt	permit. Pages Department of Important; if is any Injury or o	W V	21. Signature of Funeral Service Lies	nam	M00382	933 Gist	eral & C Ave Sil	remation ver Spri	ng MD 2	es 0910		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bis-ase or milury that initiated events)	a. Coro	d the death. Do not eline. nary Ather s a consequence of): s a consequence of):			ac or respiratory a	rrest,		Approximate Interval Between Onset and Death Months	
.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 € ₩ 0 9 □ Unknown	_d23c. If yes, outcome	2 Fetal death 3	□Ectopic pregnand	:y			ate of deliver	y Day Year	_
Q	es ign be	by	Part II. Other significant conditions of		out not resulting in the	underlying cause g	ven in Part I.		_		e cause of death?	
Vital Records,		e Completed	25. Was case referred to medical					1 ☐ Yes	osy rmed? 2000No	Were autop prior to com death? 1 \(\sum \text{Yes} \)	sy findings available pletion of cause of	
ō	ਦੂ ਵਾਭ	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ent 2 ER/Outpatie ury 28b. Time ury Year) Injury	of 28c. Inju	her: 4 Nursing	eath (Check only on the Home 5 🔀 Residual Rescribe h	dence 6 Otl		-	
Division	oital or Atte urs after de oral Directo	Certification:	3 Suicide 6 Could not be determined	building, e	iury - At home, farm, s c. <i>(Specify)</i>			28f. Location (S City or Tow	vn, State)			-
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely tilled in by the funer	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ysician: To the best liner: On the basis o and manner st	of my knowledge, dea f examination and/or in ated.	29c. Licens	se number	urred at the time, o	date and place, 29d. Date signe	and due to to to ded (Month, D	he cause(s)	
	Stat		30. Name and address of person who a Rajeev Batra 111 31. Date filed (Month, Day, Year)	20 New Ha	leath (Item 23a) (Type	*		1D 20904	04-19-	-2005		
	Registra		APR	2 0 2005	Eldrous .	H. Charle	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year : 00AM **Physician** red 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner izabeth enter imore Vursina If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Oct. 21, 1931 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 M 2 F 212-30-9415 73 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County other traumatic event, the Medical Examinar must be notified at 1 Yes XX No Director Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 907 Beacon Way 21401 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 11. Marital Status Black, White, etc. 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Specify: If Yes, Give Year or Dates: Specify White 3 ☐ Widowed 4 ☐ Divorced 1955-57 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Telecom 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Michael Frederick Francine E. Furst ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anne Frederick (Wife) 907 Beacon Way, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If sny injury or once. 4-18-2005 New Cathedral Cem. Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death Immediate Cause (Final ars **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner PAYS eron a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 | Fetal death 3 Ectopic pregnancy ō Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 4 Onknown 3 Probably 1 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 ☐ Yes 2 **D**Mo or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hospital pellil 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ledicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 (Name and address of person who completed cause of death (Item 23a) (Type, Print) 1611 715

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

			1 - For State Registrar	State of Maryland / Dep.	artment of Health and rtificate of Death		ene g. No.2 0 0 5	13355		
			Decedent's Name (First, Middle, Las.		timouto or Doutin	2. Date of Death		3. Time of Death		
	Physici		Claudine H.	Felton		Month 04	Day Year 09 2005	5:45 a ^M		
,	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		4c. County of Deat			
	-		Howard County C	General Hospital	Columbia		Howard			
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Min	(Month, Day,	Year) 9. Birtl	nplace (State or Foreign untry)		
	Director		225-42-1634	70 Yrs.		11/07/1	934 No.	Carolina		
	land W		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits		
	Mary -f sh	ţō	Md N/A	Baltimo	rΩ			1 XYes 2 ☐ No		
	n 18e	irec	10e. Street and Number	DATCIMO	10f. Zip Code	10	g. Citizen of What Co	untry?		
	23a o	aD	1113 Kevin Road	ł	21229		USA			
	ems ems	ıner	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, White			
36	ours after death with the Marylar ral', or Items 23a or 28e-f show Examiner must be notified at	Ŋ.	1 ☐ Never Married 2 ☐ Married **Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ▼ No Specify:		Specify: B	lack		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show he Modical Examiner munt be notified at	Completed by Funeral Director	15. Decedent's Ed		dent's Usual Occupation	11	6b. Kind of Business/	ndustry		
15	nin 72 n "na Medik	plet	(Specify only highest grad	College (1-4or 5+) (Give	kind of work done during most of w DO NOT use retired)	orking		,		
212	filed with Hygiene. thar thau	E	12	Coc	ok	M	d. Dept	of Corr.		
힏	be filed tal Hygid d other	Be C	17. Father's Name (First, Middle, Last)			ame (First, Middle, M				
ylai	should be filed within nd Mental Hygiene. I marked othar than umatic event, the Mental t	2	Clarence Harre			e Harrel	1.077			
Maryland	E a a		19a. Informant's Name/Relationship (7) Delores A. Felto		ng Address (Street and Number or I					
	permit, Pages 1 and 3 Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition	20b. Place of Dispo	Ayleshire Roa		Ore, Md. 2 Oc. Location - City or			
Baltimore,	Pages nent of I		1 XBurial 2 ☐ Cremation 3 ☐	Removal from State cemetery, cre	matory or other place)					
Ħ	permit, Pa Departmen Important: any injury once.		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License 	see / 2.	${ m ill}$ ${ m Cemetary4/}$ 2. Name and Address of Facility					
Ba	permit. Departr Importa any inj		· CONIS	/ LESTODE	step Brothers 300 Eutaw Plac	Funeral	Service,	1217		
	J W HILL		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do not en	ter the mode of dying, such as cardi	ac or respiratory arres	st,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Acute Stroke			1	Onset and Death Hours		
	/Medical		resulting in death)	Due to (or as a consequence of):						
н	Examiner		Sequentially list conditions.	Sepsis / Endocarditis Days						
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entai Underlying Cause (Disease or injury	Due to (or as a consequence of):		Dorre				
_	xecute and Il-tran	хап	that initiated events resulting in death) Last	c. Infected Liver Due to (or as a consequence of):				Days		
760,	death certificate be executed e attending physician and od for use as the burial-transit	ical E								
687	tificate ng physi as the			0.						
Вох	leath certificat attending phy I for use as th	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [☐Ectopic pregnancy		23d. Date of deli	*		
	death	sicia	in the past 12 months? 1 Yes 2 No		Other (specify)		Month	Day Year		
P.0	res that the designed by the a	Physician/Med	9 Unknown		and the second of Board	22a Did taba	acco use contribute to	the source of death?		
ŝ	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant conditions co	ontributing to death but not resulting in the u	inderlying cause given in Part I.			bably 4 \(Unknown		
Records,	w require been si should l	Completed								
3ec	The law cate has I page 2 s	id m				24a. Was an autopsy perform	prior to d	opsy findings available ompletion of cause of		
<u>a</u>			25. Was case referred to medical		OS Blace of D	1 ☐ Yes 2	No 1 ☐ Yes	2 No		
Vital	ii jiji k		evaminer?	Hospital: 1 XInpatient 2 ☐ ER/Outpatie	Othor		ice 6 Other (Spec	ifv)		
	rsician: Th s certificate director, pag	o Be	1 ☐ Yes 2X No				v injury occurred	,,		
of	g Physician: er this certifici eral director,	၉	27. Manner of Death		f 28c. Injury at	280. Describe nov	v Injuly occurred			
	anding Physician: ath: or: After this certific	၉	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 \(\triangle \text{Yes} 2 \subseteq \text{No} \)	28d. Describe nov	Vinjury occurred			
	r Attanding Physician: for death. iractor: After this certific t by the funeral director.	၉	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	M 1 □ Yes 2 □ No		eet and Number or Ru	ral Route Number,		
Division of	or Attanding Physician: fter death. Diractor: After this certific in by the funeral director.	Certification: To	27. Manner of Death 1 X Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 □ Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Ru State)			
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	or Attanding Physician: fter death. Diractor: After this certific in by the funeral director.	၉	27. Manner of Death 1 X Natural 2 \square Accident 3 \square Suicide 4 \square Homicide 29a. Certifier 27. Manner of Death 5 \square Pending investigation 6 \square Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury · At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office h occurred at the time, date and place	28f. Location (Str. City or Town, ce, and due to the car	eet and Number or Ru State) use(s) and manner as	stated. to the cause(s)		
	ttanding Physician: death. tor: After this certific r the funeral director.	edical Certification: To	27. Manner of Death 1 X Natural 2 \(\text{Accident} \) 5 \(\text{Pending investigation} \) 3 \(\text{Suicide} \) 4 \(\text{Homicide} \) 29a. Certifier (Check only one) 27. Manner of Death (color of D	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury · At home, farm, st building, etc. (Specify) 28i. Time of Injury · At home, farm, st building, etc. (Specify)	M 1 □ Yes 2 □ No reet, factory, office h occurred at the time, date and plaivestigation, in my opinion, death occurred.	28f. Location (Str. City or Town, ce, and due to the car	set and Number or Ru State) use(s) and manner as se and place, and due	stated. to the cause(s)		
	or Attanding Physician: fter death. Diractor: After this certific in by the funeral director.	edical Certification: To	27. Manner of Death 1 X Natural 2	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury · At home, farm, st building, etc. (Specify) 28i. Time of Injury · At home, farm, st building, etc. (Specify)	M 1 Yes 2 No reet, factory, office h occurred at the time, date and plain vestigation, in my opinion, death occurred at the time, date and plain vestigation, in my opinion, death occurred at the time, date and plain vestigation, in my opinion, death occurred at the time, date and plain vestigation, in my opinion, death occurred at the time, date and plain vestigation.	28f. Location (Str. City or Town, ce, and due to the car	set and Number or Ru State) use(s) and manner as se and place, and due	stated. to the cause(s) Pay, Year)		
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DHMH 17 Rev 1/2001

Registrar

			1 - For Registrar	State of I		artment of Healt			005	13356
			1. Decedent's Name (First, Middle	, Last)			2. Date of	Death		3. Time of Death
	Physicia /Medic		Geraldine		W.	Griffin	Apri]	Day 14	Year 2005	10:30p M
	Examin		4a. Facility Name (If not institution,	give street and number		4b. City, Town, or Locati			ounty of Death	
			Gilchrist Nu	sring Hom	e	Towson		Ba	ltimo	re
F	uneral			6. Sex 7	Age (In yrs. last birthday)		der 24 Hrs. 8. Date of I			nplace (State or Foreign untry)
N	irector		214-26-5646	1□MXXF	90 Yrs.	Montals Days Hou		15		MD
5 0 B	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				104 1-14-05-11-5-
4-14.0 :30P	sho	5		144						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
4.14.c 10:30P death with the Maryland	, or Itams 23a or 28a-1 show a ninerust be nutified at	Funeral Director	10e. Street and Number	ltimore	White	Marsh		T		
100 mg	a or	급				10f. Zip Code		10g. Citizer	n of What Cou	intry?
eath 0	18 23	eral	5503 Kathryn 11. Marital Status	12. Was Decede	at Ever in II S 13	2116			U.S.A	
Ter d	liner I	Ë	1 Never Married 2 Marrie	Armed Force	s?	Was Decedent of Hispanic If Yes, specify Cuban, Mex	cican, Puerto Rican, etc.)	No- 14.	Race - Ameri Black, White,	
07 036 urs al	- T	by	3√□ Widowed 4 □ Divorced	1 ☐ Yes % [If Yes, Give Year or Date:	s:	1 ☐ Yes 2 🔀 No Spec	cify:	Sp	ecity: R	lack
2.17-C. D.17. 1215-0036 within 72 hours after	etur Icali	Completed	15. Decedent'	s Education	16a. Dece	dent's Usual Occupation		16b. Kind	of Business/In	
2 P. C. 1215-	. E 5	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4c	(Give	kind of work done during r DO NOT use retired)	nost of working			,
217 A	other there	mo;	12th grade	2yrs		ecretary		Cit	v of i	Baltimore
and and	= =	Be	17. Father's Name (First, Middle, L				other's Name (First, Midd	lle, Maiden Su	mame)	Dar Criticite
arylaı should b	rked	To	Oliver Marrit	+		Ger	orgia L'My	hor		
larylan 2 should be	7 la marke traumatic		19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street and Nu	mber or Rural Route Nun	nber, City or To	own, State, Zij	p Code)
e, M	- E		Joan A. Obens 20a. Method of Disposition	stine-Dau	ghte r 5503	Kathryn's	s Ct. Whit	e Mar	sh. Ma	1 21126
S -			20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place)	Date	20c. Locat	ion - City or T	own, State
T E gg	int: If		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		(e	Memorial E	 ark 4/21/	05 22	011 + 11 6	ьма
altimor	Important: If any injury or once.	1	21. Signature of Fune Service L	icensee	22	. Name and Address of Fa	acility	UJ AL	Julusi	Ma
m & & &	any ir		Short	- K. Jan	Ma 13	rch F/H We	est	4	24.7	01015
			23a. Part1. Enter he disease, or o	omplications that caus	ed the death. Do not ent	800 Wabash er the mode of dying, such	as cardiac or respiratory	arrest,	, Ma	21215 Approximate
Phy	sician		shock, or heart failure. List o	nly one cause on each	1 10 50	Danie	1000			Interval Between Onset and Death
	ledical		disease or condition resulting in death)	a	as a consequence of):	Jemen	19			years
Exa	miner			530 10 (01 0	23 4 0011304061106 01).					
		Sequentially list conditions, if any, leading to immediate cause, enter noncering Cause (Disease or injury								
√ bein	ansit	Examiner	Cause (Disease or injury that initiated events							
60, he executed	sician and burial-transit	Exa	resulting in death) Last	Due to (or a	as a consequence of):					
8760, sate be ex	hysicia the bur	licai		d. —						
68	as th	edi								
Box eath cert	attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom				23d	. Date of delive	ery
deat	ed by the atte detached for	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of death 5	Ectopic pregnancy Othar (specify)		12	Month	Day Year
O. #	by the tached	hys	9 🗆 Unknown	9□ Unknown						
Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate after death.	pe de	by P	Part II. Other significant condition	s contributing to death	but not resulting in the ur	nderlying cause given in Pa	art I. 23e. Did	tobacco use	contribute to th	he cause of death?
T quire	been sig	edt					1] Yes 2 (2) N	o 3 Prob	pably 4 ∐Unknown
20 8	s been 2 should	Completed					24a. Wa	is an 2	4b. Were auto	opsy findings available
R	certificate has birector, page 2 s	Eo					per	opsy formed?	death?	mpletion of cause of
	is certificate ha	O	25. Was case referred to medical			26 01	1 ☐ Yes ace of Death Check only	2 🗓 No	1 🗌 Yes	2 □ No
f Vi	direc	To B	examiner? 1 □ Yes 2 YNo	Hospital:	tient 2 🗌 ER/Outpatien	Other	Nursing Home 5 Re		Othor (Specif	salar calar
o 4	er this eral dir	<u>.</u>	27. Manner of Death	28a. Date of In		28c. Injury at Work?	-	how injury oc	200	110sp19
Vision Attending	r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year) Injury	Work? M 1 ☐ Yes 2	□No			
ViS Atte	acto by th	<u> </u>	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of I	njury - At home, tarm, stre	eet, factory, office			ımber or Rura	al Route Number,
Di salor safte	in De	Certification;	4 [] Hornicide	building,	etc. (Specify)		City or 1	own, State)		
Hospital			29a. Certifier 12 Cartifying (Check only 2 Madical E	Physician: To the bes	t of my knowledge, death	occurred at the time, date	and place, and due to the	e cause(s) and	l manner as st	tated.
the H	ha Fi	edical	one)	and manner s	of examination and/or invistated.	restigation, in my opinion, o	death occurred at the time	e, date and pla	ce, and due to	the cause(s)
To t	Tot		29b. Signature and title of certifier	1010		29c. License numbe	er O o o	29d. Date si	gned (Month.	and the same of th
		ł) XIII CO	UV W)	Nag	303	April	F 4	2005
	1.		30. Name and address of person w	ho completed cause of	death (Item 23a) (Type, I	Print)	2 15			
	0		MANON CHAN	ies mi	6601 N.Cl	rint) rance St 1	raumon in	n UZe	X	
	Stat	e	31. Date filed (Month, Day, Year)	R 2 0 2085	trar's signature	1				
	Registra	ir	O.F.	11 20 2000	places D	Morre				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 12 2005 4:45 AM Robert Arthur Golden, Sr. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Braddock Heights Frederick Vindobona Nursing Home 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 ☐ F 88 New Jersey Director 138-01-6291 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Point of Rocks Maryland Frederick Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21777 U.S.A. 1502 Potomac Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Iten any injury or other traumatic event, the Modical Externation 2 No 1942 1 Never Married 2 Married Yes 2 f Yes, Give Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ð 1946 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tailor Clothing 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lottie Richardson John Thomas Golden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Golden, Jr./Son 1502 Potomac Avenue, Point of Rocks, MD, 21777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2 □ Cremation 3 □ Removal from State Rolling Green Memorial Park 04/18/2005 West Chester, Pennsylvania ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street Mª Millian Kisan Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Squamous Cell Carcinoma of Face /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence of) Examine be executed Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical as the t d IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ þe Blood loss Anemia, Aspiration Pneumonia 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perforn 1 Yes 2X No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Division or Attending 5 Pending 1 XNatural s after death. investigation 1 🗌 Yes 2 🗌 No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Hospital within 24 hours a 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D61172 April 12, 2005 Lorde Con 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Seventh Street, Frederick, Maryland, 21701 Ronnie Jacobs, MD, PrimeDoc, 31. Date filed (Month, Day, Year) 2. Registrar's Signature APR 2 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

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,			For State Registrar	State of N	raryland /	Certificate of		vientai H	ygienę". U Reg. No.	GUI	13358																
	Physic		Decedent's Name (First, Middle) Leland Glenn	,				2. Date of D Month April	Day	Year 05	3. Time of Death																
	/Medi Examir		4a. Facility Name (If not institution,		r)	4b. City, Town,	or Location of Death			ty of Deeth	05:30 p.™																
1			Prince George's	Hospital Co	enter	Cheve	rlv		Prin	ce Geo	orge's																
	Funeral Director		5. Social Security Number 213–58–5812		ige (In yrs. last b		r If Under 24 Hrs.	8. Date of E (Month, I 8-20-	Birth Day, Year) 1951	9. Birthp	lace (State or Foreign																
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Toy	vn or Location				1	0d. Inside City Limits																
	Manyi f sho	or	Maryland Anne	Arundel		Davidsonvi	110			1.	1 Tyes 2 No																
	the 28a-	rec	10e. Street and Number	ALUIGEL		10f. Zip Code	116		10g. Citizen of	What Coun	ntry?																
	h with	I D	1531 Themes Dri	ve		2	1035			JSA	,																
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, Ite Madeal Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	If Ves Give	?	13. Was Decedent of If Yes, specify Cu		pecify Yes or No Rican, etc.)		ace - Americ ack, White, ify: Whi	etc.																
8	tural		15. Decedent			Decedent's Usual Occi	ination		16b. Kind of I																		
21215-0036	n "ne	Completed	(Specify only highest	grade completed)	.5.)	 Decedent's Usual Occu (Give kind of work don- life. DO NOT use retir 	e during most of worked)	king			Suburban																
212	filed with Hygiene. Ither thai	mo:	Elementary/Secondary (0-12)	College (1-4or		ectrical Te	chnician			_	mmission																
B	e filed al Hygie I other vant, II	Be C	17. Father's Name (First, Middle, L				18. Mother's Nam	e (First, Middl	le, Maiden Surna	me)																	
Val	Ments Ments arkad	To	Ferris Le	land Grow			Anr	nie Smi	th																		
Maryland	s 1 and 2 should be filed withir if Health and Mental Hygiene. item 27 Is marked other than other traumatic avant, Ite Ma		19a. Informant's Name/Relationsh	p (Type, Print)	191	b. Mailing Address (Street	at and Number or Rui	ral Route Num.	ber, City or Towr	n, State, Zip	Code)																
	1 and 2 Health tam 27		Kathy L. Grow/	Wife	1	531 Themes																					
Baltimore,	Pages 1 nent of H int: If ita		20a. Method of Disposition 1 Darial 2 XCremation	3 □Removal from State		of Disposition (Name of ery, crematory or other pl	ace)	Date	20c. Location	- City or To	wn, State																
Ë	permit. Pag Department Important: I any injury o		'4 □Donation 5 □Other (Sp		Kal	as Cremator			Edgewa																		
Bal	permit. Departri Imports any inju		21. Signature of Fune Service L	censee		22. Name and Addi	-		. Kalas																		
			23a Part1 Enter the disease or o	omplications that cause	od the death. Do		omons Isla			er, M	ID 21037 Approximate																
ı	Pnysician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	_ a	e d e d s a consequence	INI	nes	or respiratory	arrest,		Interval Between Onset and Death																
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587	ficate phys s the	Medical		d																							
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Δ.	that t ed by detac		Part II. Other significant condition	s contributing to death	but not resulting i	in the underlying cause g	ven in Part I.	23e. Did	tobacco use con	tribute to the	e cause of death?																
cords	The law requires that the ste has been signed by th bage 2 should be detache	e Completed by		eted by										D					Hypertersi	re Cordio	voscuk	2 Dise	arl	1 🗆	Yes 2 No	3 🗆 Proba	ably 4 Unknown
Vital Records,			25. Was case referred to medical					1/12 Yes	opsy ormed? 2 \(\text{No} \)	prior to con death?	osy findings available inpletion of cause of																
<u>=</u>	Physician: this certificatal director,	o B	examiner?	Hospital: 1 🔀 Inpat	ient 2 ER/Or	utpatient 3 DOA	26. Place of Death			- (0																	
10	g Phy er thi	n: T	27. Manner of Death	28a. Date of Inj	ury 28b.	Time of 28c. Inju	iry at		idence 6 Oth)																
Division	Attanding I ir death. ector: After by the funer	atlo	1 □ Natural 5 □ Pending 2 □ Ccident investiga	tion 4 Month Di	3 1//	Injuly We	Yes 2 □ No	Subje	A Fel	1																	
Vis	ial or Attandi s after death. al Director: A ad in by the fu	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28 Pla 2 of In	jury - At home, fa	arm, street, factory, office	0-1	28f. Location	(Street and Numi	ber or Rural	Route Number,																
	tal or rs afte al Dir	Certification;		building, e	Const	ruetion	site 1	Vester	NI Brown	Al)e	pot																
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by th	Medical	29a. Certifier 1 ☐ Certifying 2 ☐ Medical E	Physician: To the best caminer: On the basis of and manner s	of examination ar	e, death occurred at the tod/or investigation, in my	ime, date and place, opinion, death occurr	and due to the red at the time	, date and place,	anner as sta and due to	the cause(s)																
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	4.10			se number	1	29d. Date signe	ed (Month, E	Day, ear)																
•	116		1 like	MU)			CME		April	13, 2	005																
7	2		30. Name and address of person w	UGGI M	death (Item 23a)	(Type, Print) 111	Penn Stree	t Bal	timore,	Maryl	and 21201																
ý.	Sta Registr	0.	31. Date filed (Month, Day, Year) APR 2 0	2005 32 Regist	rar's Signature	Sporte																					
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hysician	1. Decedent's Name (First, Middle,	en #17 per fh	J 21V		2. Date o	Reg. No.	4000	3 Tim er Death
Medical	Asa Winfield Gra				Apri	1 15,	2005	1:00
xaminer	4a. Facility Name (If not institution, 7837 Chestnut Gr			4b. City, Town, or Locatio	n of Death		c. County of De	
neral		6. Sex 7. Age (in v	rs. last birthday)		er 24 Hrs. 8. Date o	f Birth	rederic	K irthplace (State or Fore Country)
ctor	216-40-9773	1X M 2□F	52 Yrs.	Months Days Hours	Min. (Month	Day, Year 3, 19	42 Nor	th Carolin
	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limi
ξ	Maryland Frederi		ederick					1 🗆 Yes 2 🔀 N
Director	10e. Street and Number	ick Fie	delick	10f. Zip Code		10g. C	itizen of What C	Country?
	7837 Chestnut Gr	ove Road		21701		USA		
Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	13. W	as Decedent of Hispanic (Yes, specify Cuban, Mexic	Origin? (Specify Yes of an, Puerto Rican, etc.	r No-	14. Race - Am Black, Wh	erican Indian, ite. etc.
by F	1 Never Married 2 Marrie 3 Widowed 4 Noivorced	d 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		☐ Yes 2 X No <i>Speci</i> i			Specify:	
edk		Education	16a, Decede	ent's Usual Occupation		16h k	Kind of Busines	hite
Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give k life. D	ind of work done during m O NOT use retired)	ost of working	100.1	Ciria or Basines.	anidustry
EOC	12	College (1-401 54)	Superv	isor		Cor	nstruct	ion
Be (17. Father's Name (First, Middle, La	ast)	-	18. Mot	her's Name (First, Mic	dde, Maidei	n Sumame)	
၉	Asa Winfield	Sr.			ca Rivenbai			
	19a. Informant's Name/Relationshi			Address (Street and Num				
	Christine Poole,		. Place of Dispos	Chestnut Grov	re Road, Fi		Lck Mai	
	1 XBurial 2 ☐ Cremation 3	3 □Removal from State	cemetery, cremi	atory or other place)				
	' 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li			e Heights Co				
	Land ha	ע	r00999 10	Name and Address of Fac 6 East Churc	h Street	id Bas	stord Fu	ineral Hom 1D 21701
	23a. Part1 /Er er the disease, or o	omplication that caused the de					rick, r	Approximate Interval Between
	Immediate Cause (Final	nly one dease on each line.						Onset and Death
	disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of):							2 days
	Conventinh, list and distant	b Light Chair		1				6 months
iner	Sequentially list conditions, if any, leading to immediate cause that depth is Cause (Disease or injury that initiated events	Due to (or as a cons						
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
E	rooming in double, but	Due to (or as a cons	equence of):					
edical	l ·	d.						1
/Me	IF FEMALE:	23c. If yes, outcome of preg	nancy				2215.11	
cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death 3 DE	ctopic pregnancy Other (specify)			23d. Date of de Month	Blivery Day Year
lys	1 Yes 2 No 9 Unknown	9□ Unknown		Strict (Specify)		-		
by Physician/M	Part II. Other significant condition	s contributing to death but not re	esulting in the unc	derlying cause given in Par	1. 23e. D	id tobacco	use contribute t	o the cause of death?
pa pa	Hypercalcemia,	COPD, High Blo	od Press	sure, ASCVD	1	☐ Yes 2	X No 3 □ P	robably 4 Unknow
plet					24a. W		24b. Were a	utopsy findings availat
Completed					p	utopsy arformed? is 2 X No	death?	completion of cause of s 2 No
Bec	25. Was case referred to medical examiner?			26. Pla	ce of Death (Check on		10.10	20110
70	1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 DOA Other: 4 D	lursing Home 5 🔀 R	esidence	6 ☐Other (Spe	ecity)
=	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Descri	be how inju	ry occurred	
ō	2 Accident investigat 3 Suicide 6 Could no	t ho		M 1 Tes 2				
catlo			home, farm, stree city)	t, factory, office		n (Street ar Town, State		ural Route Number,
ertification	4 Homicide determine				and place, and due to t	ho onuga/a	\	
al Certification;	4 Homicide determine	Physician: To the hest of my k	nowledge death			ile causa(s) and manner a:	
	4 Homicide determine	Physician: To the best of my k caminer: On the basis of examinand manner stated.	nowledge, death on nation and/or inve	scurred at the time, date a stigation, in my opinion, de	eath occurred at the tin	ne, date and	d place, and due	e to the cause(s)
Medical Certification	4 Homicide determine 29a. Certifier 1 Certifying (Check only 2 Medical Ex	caminer: On the basis of examin	nowledge, death on nation and/or inve	stigation, in my opinion, de 29c. License number	eath occurred at the tin		d place, and due	e to the cause(s)
	4 Homicide determine 29a. Certifier (Check only one) 1 Certifying 2 Medical Expone)	caminer: On the basis of examin	nowledge, death on nation and/or inve	stigation, in my opinion, de	eath occurred at the tin	29d. Da	d place, and due	th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 2005 GILBERT ATRICIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Teyn, or Location of Death 4c. County of Death **Examiner** Hospital Baltin DWN dall Date of Birth (Month, Day, Year) 0 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 214-54-2908 1 □ M 2 XF Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be mutilised at 1 ☐ Yes 2 XNo Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Items 23a 6 Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be fitted within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or Item eny injury or other traumatic event Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Count Backmore Elementary/Şecondary (0-12) College (1-4or 5+) system stodiar School NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Delorse William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5430 Parkheints Ave. Bacto. md, 21215 mother oberts 1 or se 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State King mem. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Back. 405 Wi Ma Wallace Mancy 2792 m. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) METASTATIO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records. P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 MNo 9 ☐ Unknown the 9 Unknown s been signed by th ? should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform 200 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 🗌 Yes 70 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide dical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mella mo DHIHIO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER

DHMH 17 Rev 1/2001

State

Registrar

RAHOAU

TOWN

21133

HOSPITAL

APR 2 0 2005

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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			1 - For State Registrar		Otate of W	iai yiai ia / i	Certificate		id ivierital Fly	Reg. No	600	3361
			Decedent's Name (Fire	st, Middle, La	st)		/		2. Date of De	aath		3. Time of Death
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	Examir		4a. Facility Name (If not	institution, giv	1	4 0	4b. City, To	wn, or Location of D	Death	40	. County of Dea	th
			JOHNS HOP 5. Social Security Number	KINS /	DAYVIEW	MED (E	WIER /	SALTIM. rear If Under 24			NIA	
\$	Funeral Director		047-22-4511		1 □ M 2 🛣 F	ge <i>(in yr</i> s. last bii 74			Min. (Month, Da	ay, Year)	9. Bir	thplace (State or Foreign ountry)
	D		Usual Residence of Dece			79			October 8	8, 193	0 CT	
	anylar ahow	_		. County		10c. City, Tow						10d. Inside City Limits
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	within 72 hours after death with the Maryland ene. Than "natural", or tlems 23e or 28e-f ahow the Madical Estantine framitte notified at	by Funeral Director	10e. Street and Number 7602 Parkwo	od Por	n d		10f. Zip Co	1222		10g. Cit	izen of What Co USA	
	death	era	11. Marital Status	XXX NOC	12. Was Decedent	Ever in U.S.			? (Specify Yes or No	D-	14. Race - Ame	
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903	aral',	d by	3 X Widowed 4 □ [Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X	No Specify:			Specify: Wh	nite
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Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe ance.			mation 3	Removal from State	cemeter	Disposition (Name y, crematory or othe	r place) Ar	oril 21,		ocation - City or	
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B	permit. Departm Importa any inju		hithe	WA ((DV)	nolla	Connell	y Funeral	Home Of nt Road,	Duno	lalk, P.A	21222
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	4		30. Name and address of	person who		eath (Item 23a) (Type, Print)		^	-	.	
1			31. Date filed (Month, Day	v Yearl	32 Benistr	ar's Signature	, D.	Trum?	20	2	1724	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ľ	For State Registrar	State of Maryla	•	artment of F		d Mental Hy	giene	
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last	1ES		4b. City, Town, o	or Location of C	2. Date of De Month		Yeer 3. Time of Death 2
	Examin	er	FREDERICK VILLA	. /1	ME	BANTI		MP	BALTI	
	Funeral Director		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bin (Month, Date of Street)	ay, Year)	Birthplace (State or Foreign Country)
	Maryland -I ahow	tor	10a. State 10b. County A D JAKIM		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	or 28a	Director	10e. Street and Number	^		10f. Zip Code			10g. Citizen of W	
	Jeath w	Funeral	2 FAIRVIEW 11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	(228 Hispanic Origin	? (Specify Yes or No Juerto Rican, etc.)		USA - American Indian,
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or terms 23a or 28a-f ahow ent, the Medical Exeminer must be motified at	þ	1 Months 1 Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1		If Yes, specify Cub 1 ☐ Yes 2 KENo	an, Mexican, P Specify:	Puèrto Rican, etc.)	Specify:	k, White, etc. BLACK
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E H			25. Was case referred to medical				OS Diago of	pend 1 ☐ Yes	30 No 1	eath? Yes 2 No
ž Vi	hyelcien: this certifica al director, p	To Be	avaminer? \] ER/Outpatier		ner: 4 ursii	ng Home 5 Resi		r (Specify)
Division of	Attending Ph death. ctor: After th y the funeral	ertiflcation;	27. Manner of Death Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat rk? Yes 2 □ No		how injury occurre	ed .
DIX	or / or / or / or / or / or /	OI	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (City or To		r or Rural Route Number,
	s Hospital	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and p ppinion, death o	place, and due to the occurred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To ths within 2 To the	¥	29b. Signature and title of certifier	attend	and .	29c. Licens		3	29d. Date signed	(Month, Day, Year)
i	OP		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type,	Print)	5030			
	NO.		Rodollo E. Fr	Y nande t	MO,	Yosti	edont	MRd St	6165,0	Cationsville 21228
	Sta Registr		31. Date filed (Month, Day, Year)	2 0 2005 A	we do	Sport	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #10b&c PER FH G842 entire at 850 feath . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Michael Hernandez 5:03 AM *20*05 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location.

BOLTMORE

If Under 1 Year If Under 24 Hrs.

Adonths Days Hours Min.

Mar. 5, 1 Examiner 4c. County of Death NIA University of Maryland Medical Center 5. Social Security Num 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) **★**→ M 2□ F 217-84-3858 Director 42 ,1963 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits in than "natural", or itams 23s or 28s-f show the Medical Examinatinust be notified at N/A BALTO. **Funeral Director** Maryland -Baltimore 1 ☐ Yes 🔏 🔯 No TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 Ashlar Hill Court 21234 USA Pages 1 and 2 should be filed within 72 hours atter death vent of Health and Mental Hygiene. Sont: If item 27 Is marked other than "natural", or Itams 23. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2☑No f Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Year Laborer Private Industry or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Hernandez Carolyn Harvey ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Ashlar Hill Ct. Towson, Md 21234 Carolyn Hernandez/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Zion Cemetery 4/22/05 Baltimore, Maryland 21. Signature of Funeral Service Licens e 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown RD Baltimore, Md21215 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final infarction Physician disease or condition resulting in death) myocardial /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certiticate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

To the nospiration 24 hours after death,
To the Funeral Director: Aft

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

cal Examiner	if any, leading to in Cause (Disease or that initiated events resulting in death) I	mediate injury
yslcian/Medl	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?
rtification; To Be Completed by Physician/Medical Examiner	Part II. Other signif	icant conditio
To Be	25. Was case referrexaminer?	
rtiflcation;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investig 6 Could r

Ce

26. Place of Death (Check only on Inpatient Other:

2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work?

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed 1 ☐ Yes 2 【

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier maca Hershenso

5 Pending investigation

6 Could not be determined

29c. License number P18568

April 17 2005

1 TYes

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ressica Heishensm

Hospital:

Date of Injury (Month, Day Year)

22 South Greene Stret Baltmare MD

State Registrar

APR 2 0 2005

Registrar's Signature

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** April 11, Horace Lawrence 8:08 PM M Hart /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Hours | Min. | Feb. | 12, 1 Washington Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 65 Yrs. 6. Sex +□ M 2□ F Birthplace (State or Foreign Country) **Funeral** 577-52-9061 Director 1940 Wash., Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat, or Items 23a or 28a-1 show any injury or rother traumatic event, Ite Manical Examine mail the notified any injury or prints traumatic event, Ite Manical Examines mail the notified and MD Prince Georges 1 XYes 2 No Director Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 United States 3501 Madison Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XX Specify: þ Specify: African_ 3 ☐ Widowed 4 ☑ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto 12 Auto Service Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unobtainable unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westry Lawrence Hart/Son 12030 Berry Street, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4/15/05 Beltsville, MD Chesapeake Crematory 21. Signatury of Funeral Seprice License 2. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Athero scleroti Cocenne /Medical **Examiner** Due to for as a consequence of): fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? thyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 12 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 PER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier Alterdy D44848 (MD) Emergency 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Takoma Paula 7600 Carroll MD Humayum 31. Date filed (Month, Day, Year) 32. Registrar's Signature State lewa Registrar

			1 - For State Registrer	State of Maryla	nd / Dep		Health ar	nd Mental H		2005	13365
	Physici /Medi	al	1. Decedent's Name (First, Middle, Ricky	HAMP-	TON			2, Date of Month	D	2005	3. Time of Death
	Examir Funeral Director	ier	4a. Facility Name (If not institution, Good Samat 5. Social Security Number 6. 212-02-4516	itan Hospita	s. last birthday) Yrs.	BA		Hrs. 8. Date of (Month,			
	Ihe Maryland 28e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo			1,0171	7, 150		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
9801	ours after death with ral', or Items 23a or Examinet must be	d by Funeral Director	10e. Street and Number 2527 Salem Stree 11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?	U.S. 13.	10f. Zip Code 21217 Was Decedent of If Yes, specify Cu 1□ Yes 2戊 No	Hispanic Origin ban, Mexican, F	? (Specify Yes or verto Rican, etc.)	Uni	itizen of What Cou Lted Stat 14. Race - Ameri Black, White. Specify: Blace	es can Indian, etc.
21215-0036	be filed within 72 hours ital Hygiene. Id other then "natural", event, the Mcdical Ex	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	grade completed) College (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir stylist	e during most of red)		Cos	Kind of Business/Ir Smetology	,
Maryland	2 should be file and Mental Hy le markad oth raumetic evant	To Be	17. Father's Name (First, Middle, La Robert Hampton 19a. Informant's Name/Relationship		19b. Maili	ng Address (Stree	Janet			n Sumame) or Town, State, Zij	p Code)
Baltimore, M	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 le marka any injury or other traumetic 90ce.	,	Andrew Jenkins 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice	cify) Ch	Place of Dispo cemetery, crea nesapea	osition (Name of matory or other pi ke Crema 2. Name and Add cremation	tory In ress of Facility and Fun	eral Alte	Bel	tsville,	
	Physician / Medical Examiner Physician and physician and the printing of the	Examiner	23a. Part 1. Enter the disease, or conshook, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	ath. Do not enterprise and the property of th	ser the mode of dy	ing, such as ca			Inote, No	Approximate Interval Setween Onset and Death
P.O. Box 68760,	aath certific attending p for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	tal déath 3[Ectopic pregnan	су		-	23d. Date of deliv Month	ery Day Year
		eted by Ph	Part II. Other significant condition:	s contributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.	_ 1	☐Yes 2	Prol	he cause of death?
ital Rec	The lar ate has page 2	e Completed	25. Was case referred to medical	epstots 13	7		26. Place of	24a. W au pe 1 Ye	topsy prormed? s 20 N	24b. Were autoprior to codeath?	opsy findings available impletion of cause of
Division of Vital Records,	To the Hospital or Attanding Physician: Within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigat 3 Suicide 6 Could no	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inji	ther: 4 Nursii ury at ork? Yes 2 No	ng Home 5 🗆 R 28d. Descrit	esidence be how inju	6 ☐ Other (Special or Special or Surred or Rural or Rura	
Div	Hospital or a 4 hours after Funeral Dira iely filled in b		(Check only 2 Medicel Ex	building, etc. (Spec Physician: To the best of my kn eminer: On the basis of examin	ify) nowledge, deat	h occurred at the	time, date and p	City or	Town, Stat	e) :) and manner as s	tated.
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	and marner stated.	从	29c. Licer	nse number		29d. Da	ate signed (Month,	Day, Year)
_	·}		30. Name and address of person with BAGHL	no completed cause of death (Ite 1. Grod Samo 32. Registrar's San R 2 0 2005	om 23a) (Type,	Print) Hospital	5601 1 BALT	och ravi	MB-MD	unlevard - 2123	,3
¢i.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's 30n	nature	Joan Span	N				

			1 = For State Registrar		of Maryland / Dep	oartment e <i>rtificate</i>				Reg. No.	005	13366
П	Physici	an	Decedent's Name (First, Mide	dle, Last)					2. Date of De Month	ath Day	Yeer	3. Time of Death
	/Medi		Leicy	Irene		rtge			April	18	2005	0517 ^M
7	Examir	ner	4a. Facility Name (If not institution		•			ocation of Dea	ith	4c. (County of Death	
			Anne Arundel	_			napo				Anne Ar	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last birthda 93 Yrs.			If Under 24 Hr Hours Mir	(Month, Da	th <u>y, Ye<i>ar</i>)</u>	9. Birth Cou	place (State or Foreign intry)
	Director		218-74-8849 Usual Residence of Decedent		93 Yrs.				Sept.	27, 1	911 Mar	yland
	land w		10a. State 10b. Count	ty	10c. City, Town or	Location						10d. Inside City Limits
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	leath ns 20	era	11. Marital Status		edent Ever in U.S. 13	. Was Decede		778	Specify Yes or No		SA 4. Race - Ameri	ican Indian
(0	r Her	표	1 ☐ Never Married 2 ☐ Ma	Armed Fo	orces?			Mexican, Pue	Specify Yes or No rto Rican, etc.)		Black, White	
93	urs a	by	3 Widowed 4 □ Divorce		ve	1 ☐ Yes 2	XNo	Specify:			Specify: W	Mite
5-0036	72 hours after death with the Maryland natural', or items 23a or 28e-f show disal Evantinar must be notified at	Completed	15. Decede	nt's Education	16a. Dec	edent's Usual	Occupation	on		16b. Kin	d of Business/Ir	ndustry
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21	filed within Hygiene. ther than "	NO.	6			emaker				0wn	Home	
nd	al Hy I oth	Be (17. Father's Name (First, Middle	, Last)			18	8. Mother's Na	ime (First, Middle,	Maiden S	iumame)	
Va	Ment Ment Prkec	P	Ernest Simmon	ns				Mae Tu	cker			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28e-f show or other traumatic event. The Medical Examinar must be notified at	0 8	19a. Informant's Name/Relation	iship (Type, Print)	19b. Ma	ling Address (Street and	d Number or F	iural Route Numbe	r, City or	Town, State, Zij	p Code)
	1 and 1 Health em 27		George P. Har	rtge (Son)	490:	3 Sudle	y Ro	ad, We	st River,	MD	20778	
Baltimore,	of H		20a. Method of Disposition 1 Burial 2 □ Cremation	3 DRemoval from	20b. Place of Dis cemetery, cr	oosition (Name ematory or oth	of er place)		Date	20c. Loc	ation - City or T	own, State
Ē.	Pages ment of I ant: If ite ury or o		`4 ☐Donation 5 ☐ Other (Woodfie	Ld Ceme	tery	4-	22-2005	Gale	sville.	MD
att	permit. Pag Department Important: any injury c		21. Signature of Funeral Service	e License 0		22. Name and	Address	of Facility	Home, P.A			
	207 2 2 9		70 7			12 Rid	gely	Avenue	Annapo	lis	MD 2140	1
į.			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that of st only one cause on e	aused the death. Do not e	nter the mode	of dying,	such as cardia	c or respiratory ar	rest,		Approximate Interval Between
J.	Physician		Immediate Cause (Final disease or condition	Da	strainton	timal	2 /	load				Onset and Death
	/Medical		resulting in death)	Due to	(or as a consequence of):			-				and
4	Examiner		Sequentially list conditions	b. (1	ortee 1	reur	40	in				year
	₽ ₩	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(o as a consequence of):	•	0-					
	and trans	Examiner	that initiated events resulting in death) Last	c	mpertens	con						illan
90,	cian a	Ē	rosuling in oculin, East	Due to	(or as a consequence of):							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai		d	Duleti	~			_			gan
9	leath certific attending pl	Physician/Med	IF FEMALE:	00-14								
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	1□Live b		□Ectopic preg				23	d. Date of delive Month	ery Day Year
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9⊟Unkn		Other (spec	ify)	·			WORLD	Day real
Α.	that the de led by the a detached t		Part II. Other significant condit	ions contributing to d	and hut not coulting in the	undashina sau		in Doel (220 Did to	bassa		he cause of death?
JS,	ires ti signe	þ	Tattir. Other significant contact	ions contributing to di	saur out not resulting in the	underlying cau	se given	in Part I.			No 3 □ Prot	1 /
oro	w require been si should I	etec							'	95 ZU	140 3 FIOL	Dably 4 Conkilowii
of Vital Records,	e taw has b	Completed							24a. Was a autop	sv	prior to co	psy findings available mpletion of cause of
Ξ.		Cor							perfor 1 ☐ Yes	2 No	death?	2 No
Vita	Physician: Th this certificate al director, paç	Be	25. Was case referred to medical examiner?		/				ath Check onl or			
of	Physical direction	스	1 ☐ Yes 2 ☐ No		npatient 2 ER/Outpatie		Other:	4 Nursing	Home 5 Resid	ence 6	Other (Specif	ý)
n c	ing After une	ion	27. Manner of Death 1 ☐ Natural 5 ☐ Pendi	rig	of Injury 28b. Time th, Day Year) Injury		. Injury at Work?		28d. Describe h	ow injury	occurred	
Sic	Attending r death. sctor: After by the funer	cat	2 Accident invest	I not be	Alei au	М		s 2 □No	00/1 1/1			
Division		Certification:	4 Homicide determ	mined 286. Place	of Injury - At home, farm, s ng, etc. <i>(Specify)</i>	treet, factory, o	office		City or Tow		Number or Rura	al Route Number,
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	24 hc 24 hc Fun etely	edical	(Check only 2 Medica	Exeminer: On the ba	best of my knowledge, dea asis of examination and/or in her stated.	nvestigation, in	tne time, my opini	date and place ion, death occ	e, and due to the d urred at the time, d	ause(s) a late and p	nd manner as s lace, and due to	tated. o the cause(s)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Med	29b. Signature and title of certific		stated.	29c. L	icense n	umber	2	29d. Date	signed (Month,	Day, Year)
	- 3 + 8		1 then 1	Varia-	mo			3111		41	181	
1	11		30 Namkand address 1	y access	o of dooth (les - co-)			. ,			/	,
6) (30. Name and address of person Hang J. Davi		e of death (Item 23a) (Type 2001 Medica	1 Park	wav.	Annapo	olis. MD	2140	1	
	Sta	te	31. Date filed (Month, Day, Year		egistrar's aignature	7. 10	de	P				
	Registr		A	PK Z U ZUU	S JOHNSON S	1						

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			Decedent's Name (First, Middle, Last)						of Death			3. Time of Death
	Physici /Medi		Myrtle Holley					C4			os.	12:01 PM
1	Examir		4a. Facility Name (If not institution, give street and num			4b. City, Town, o	r Location of D	eath	4	c. County of I		
			Union Memorial Hospi 5. Social Security Number 6. Sex		1125 (1	Ba If Under 1 Year	ltimor				n/a	
	Funeral Director		216-34-4008 1 M XXF	7. Age (In <i>yrs. last</i> 87	Yrs.	Months Days	If Under 24 Hours	Min. 8. Date	of Birth hth, Day, Yea 1 - 191	8 9.	Birthpl Count V1 Y	ace (State or Foreign try) 'ginia
	iend ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10	Od. Inside City Limits
	e-fsh	tor	Md n/a	В	alt.	imore						1 Nes 2 No
	or 28	Olre	10e. Street and Number	•		10f. Zip Code			10g. C	Citizen of Wha	t Count	ıry?
	s 23a	rai	2700 N. Charles Str			212				USA		
036	d within 72 hours after deeth with the Marylend jiene. r than "natural", or Items 23a or 28e-f show Its Madical Examination indiffied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Armed Foi	≱ (□ X N∘	- 1	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No		? (Specify Yes uerto Rican, e	s or No- tc.)	14. Race - / Black, V Specify:	Vhite, e	etc.
2	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed)	1	6a. Deced	lent's Usual Occup	ation during most of	workin a	16b.	Kind of Busine	ess/Ind	ustry
7121	73 75 15 15	Completed	Elementary/Secondary (0-12) College (1	4or 5+)		kind of work done of NOT use retired				Housev	vif	е
Baltimore, Maryland 21215-0036	g d a b	To Be	17. Father's Name (First, Middle, Last) James Hart					Name <i>(First, 1</i> Virgii				
/ar			19a. Informant's Name/Relationship (Type, Print)			g Address (Street						
e, e	of Heelth of Heelth litem 27 t		Joseph Lee Holley Jr.		567/	Wesley	Aven	ue Bai	ltimon	re Md Location - City	21	207
o E	permit. Pages of Department of Histophysist in the any injury or ot once.		X\\ Burial 2 \(\text{Cremation} \) 3 \(\text{Removal from S} \) `4 \(\text{Donation} \) 5 \(\text{Other} \) (Specify)	ceme	y I a n	natory or other place Id Natio	nal 4	-23-05	5 t	aurel	, i	Md
Rail	permit Depart Import any inj		21. Signature of Funeral Service Licensee Brandon Wylie	per dvr	6	Name and Address	ilmor	Wylie Stree	Funer	ral Ho	me	P.A. Md 2121
2	Physician /Medical			ich line.	o not ente	er the mode of dyin	g, such as car	diac or respira	tory arrest,			Approximate Interval Between Onset and Death
	Examiner		9= 0	TIC SHO								20 MIN
	sit ed	ılner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury	or as a consequence	ce of):							
8/60,	cate be executed physicien and the burial-transit	al Examin	that initiated events	or as a consequenc	ce of):						1	
289	ficate physics the l	edical	d.	1991								
O. Box	he death certificate be executed the attending physicien and ched for use as the burial-transit	Physician/Me	in the past 12 menths?	come of pregnancy th 2 Fetal dea ant at time of death wn		Ectopic pregnancy Other (specify)			_	23d. Date of Month		y Day Year
7	The law requires that the de ate has been signed by the a page 2 should be detached t	by	Part II. Other significant conditions contributing to de	ath but not resulting	g in the ur	nderlying cause give	en in Part I.	23e		1		cause of death?
		Completed						24a.	Was an autopsy performed? Yes 2.☑N	prior	to com	sy findings available pletion of cause of
<u> </u>	Physician: Th r this certificate ral director, pag	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Nr			Othe		Death (Check				
on or		tion: To	27. Manner of Death 28a. Date of		Dutpatiens Time of Injury	28c. Injury Work	at at		Residence	6 Other (Sury occurred	pecity)	
DIVIS	To the Hospitel or Attending Ph within 24 hours eiter death. To the Eunerel Director: After th completely filled in by the funeral	Certification:	a Cloudette CC Could not be	of Injury - At home, g, etc. (Specify)	farm, stre	eet, factory, office		28f. Loca City	tion (Street a or Town, Stat	nd Number or te)	Rural	Route Number,
	To the Hospitel or At within 24 hours effer of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the ba and mann	sis of examination	lge, death and/or inv	occurred at the timestigation, in my or	e, date and pl	ace, and due t	o the cause(s time, date ar	s) and manner and place, and o	as stat	ted. he cause(s)
M	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License			29d. Da	ate signed (Mo	onth, Da	ay, Year)
5	0		M.D.		i	AT243	3946-	E13	00	- 18 -	200	25
TF	X>		30. Name and address of person who completed cause SHAHZAD A. USMAN1, 26	of death (Item 23a		•	PKWY	, DAL	TIMOR	E M	D	21218
	Sta Registr			gistar's Signature								

-			1 - For State Registrar		State of Ma	rylan			nt of He te of De		Mental Hy	/giene	00	5 10	336
	Physici /Medio Examir	cal	1. Decedent's Name (Fit CHARLES 4. Facility Name (If not	SEFFRE	treet and number)			4b. City	Town, or Lo	ocation of Deal	2. Date of Di Month APRIL	Day	Year 2005	3. Time of	Death P M
	Funeral Director		5. Social Security Number 228 · 28 · 377 Usual Residence of Dec	er 6. Sex 1 ☑	M 20 F	ANCE (In yrs. 1	last birthday) Yrs.	If Under	r 1 Year	UNCE f Under 24 Hrs Hours Min.	8. Date of Bi	irth ay, Year) 1929	9. Birth	place (State o	or Foreign
	h the Maryland r 28a-f show	Irector	10a. State 10b	ALTMORE	É		y, Town or Lo	LE	o Code			10g. Citizen o		10d. Inside Ci 1 ☐ Yes ntry?	
036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or floms 23s or 28s-f show event, tra Medical Evant actinual to notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Wildowed 4	2 Married	AVENUE 2. Was Decedent B Armed Forces? 1 by Yes 2 N If Yes, Give Year or Dates:	ver in U.				anic Origin? (S Mexican, Puer Specify:	pecify Yes or Noto Rican, etc.)		usa ace - Ameri lack, White, cify: BLA	etc.	
121215-0036	filed within 72 ho Hygiene. ther then "netur int, tra Medical	Completed	15. (Specify of Elementary/Secondar 12. TH. GRADE 17. Father's Name (First	2	ation completed) College (1-4or 5	+)	(Give I	kind of wo	POLICE	ing most of wo		16b. Kind of	Business/Ir		
Maryland	should be find Mental Firmarked of	To Be		FFREY	e, Print)		19b. Mailin	g Addres	L	ILLY BI	me (First, Middle UMPERS ural Route Numb			Code)	
	es 1 and 2 of Health a f Itam 27 Is r other trau		SHEREE C. 20a. Method of Dispositi 1 K Burial 2 Cr	оп	•	20b. P		LEX A	ANDER		CATONS	_	Mo	21228	3
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Itam 27 Is marke any injury or othar traumatic QDC8.		*4 Donation 5 D	Other (Specify)	1	CRO	WNSVII		nd Address of		12.05 UNERAL E, BALTO	CROWN	SVILLE	MD	
	Physician /Medical Examiner	-	23a. Part 1. Enter the dishock, or hear fall Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate the sequential in the sequ	(a.	11- 11	consequence of a conseq	n. Do not ente	or the mod	de of dying, s	such as cardia	c or respiratory a	arrest,		Approximate Interval Bets Onset and D	ween Death WS
68760,	ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	-	Due to (or as a	consequ	uence of):								
P.O. Box	Physician: The law requires that the death certifical this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregin the past 12 moni 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	riarit	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic p Other (sp					ate of deliv Ionth	,	/ear
ords, P	w requires that been signed I should be det		Part II. Other significant	1 1	1	t not resu	ulting in the un	derlying o	ause given i	n Part I.		tobacco use co Yes 2 □ No	ntribute to t 3 ☐ Prot		eath? Jnknown
al Rec	n: The law i ificate has bo or, page 2 sh	e Completed	25. Was case referred to	a madical							1 Tes	psy ormed? 2 No	were auto prior to co death? 1 Yes	psy findings a mpletion of ca 2 \(\text{No} \)	available ause of
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	To B	examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 (2 Accident	Ho ☐ Pending Investigation	ospital: 1 x Inpatier 28a. Date of Injur (Month, Day	,	ER/Outpatient 28b. Time of Injury		Other: 28c. Injury at Work?		ome 5 Resi 28d. Describe	dence 6 🗆 O		y)	
Divis	oital or Atte urs after de aral Directo	Certification:	4 Homicide	Could not be determined	28e. Place of Inju building, etc	. (Specify	·) 				28f. Location (City or To	wn, State)			ber,
	To the Hospital or within 24 hours afte within 24 hours afte To the Funeral Dir. completely filled in It.	Medical	29a. Certifier 1 2 2 one) 2 . Signature and title 0	medicei examini	cian: To the best o er: On the basis of and manner stat	examınat	wledge, death ion and/or inv	estigation	at the time, , in my opinion. c. License nu	on, death occu	, and due to the rred at the time,	cause(s) and n date and place 29d. Date sign	, and due to	the cause(s)	
	10	7	30. Name of address of	up de	npt ted cause of de	ath (Item	23а) (Туре, F	Print)				_		le, 20	205
	Sta Registr		31. Date filed (Month, Da	ay, Year) APR	32. Registra 2 0 2005	r's signat	ure b	00 K A	park	SAVE.	POLLT	IMORE		212	29

			1 - For State Registrar	Otato or ivid	a. y (\(\alpha\)				Death	iid iv	lental Hy	gierie Reg. No. 2 (0.05	13360
	Physici /Medic Examir	cal	Doesedent's Name (First, Middle, Las DUBOLS 4a. Facility Name (If not institution, give	John.	SON	,	4b. City.	Town, or	Location of	f Death	2. Date of De Month APRIL	Day 8	Year 2005 y of Death	3. Time of Death
	Funeral	ľ	Howard County Ger 5. Social Security Number 6. Se	neral Hosp		last birthday) Yrs.	If Under	Col	umbia If Under 2 Hours		8. Date of Bird (Month, Da Jan • I		Howar	cd place (State or Foreign
	Director show		Unavailable) Usual Residence of Decedent 10a. State Maryland Montgot	norv		y, Town or Lo		ror (Spring		Jan. 1	0,1904		1ington DC 10d. Inside City Limits 1 □ Yes 🙀 No
	th with the 23a or 28a- ust be notifi	ai Director	10e. Street and Number 11624 Stewart Lan		<u> </u>		10f. Zip		20904			10g. Citizen of United		ntry?
900	s 1 and 2 should be filed within 72 hours after death with the Maryland if mattend Mental Hygiene. If marked other then "naturel", or Items 23a or 28a-f show other treumetic event, It's Maxical Examinations to notified at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:		1	Was Deced f Yes, spec l ☐ Yes		ispanic Orig n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla Specin	ick, White,	can Indian, etc. 31ack
121	filed within 72 h Hygiene. other then "natuent, II's Marical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) N/A	ucation de completed) College (1-4or 5 N/A	+)		lent's Usua kind of wor DO NOT us er Wo	rk done d se retired	during most)	of worki	ng	16b. Kind of E	Jusiness/In	dustry
ryland	should be filk ind Mental Hy i marked oth umetic event	To Be	17. Father's Name (First, Middle, Last) Elias Boo 19a. Informant's Name/Relationship (7	ldie		10h Mailin	n 0 d d a a a a	/Can a 4	Dai	.sy	Ann	Maiden Suma Jo or, City or Town	hnson	
	0 0 == =		Daisy Ann Johnson 20a. Method of Disposition 1□Burial 2XCremation 3□	n / Mother	20b. P	11624 lace of Disposemetery, crem	Stew sition (Nan natory or o	art ne of ther plac	Lane	#403	3; Silv	er Spri 20c. Location	ng, M	D 20904
	permit. Pag Department Importent: I eny injury o		4 □ Donation 5 □ Other (Specify. 21. Signature of Funeral Service License	600	oo 38	sapeak Ra 22 Ra	. Name an pp Fu	d Addres	s of Facility	/20, Cre		Belts Servic		
	nysician (Madical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lin a.	the death ne. SE	PSIS								Approximate Interval Between Onset and Death
by	Medical Examiner hysician and the prival-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	ACT	ERIAC					it Pellit Vien	eß,		-
Box 6	eath certificate attending phys for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at	of pregnar 2 □ Fetal	ncy death 3	Ectopic pro	egnancy	enge	<i>- CI</i>	Cen,	23d. Da	ite of delive	ery Day Year
s, P.O	es that the igned by th be detache	by	9 □ Unknown Part II. Other significant conditions co	9⊡ Unknown	ıt not resu	ulting in the un	derlying ca	iuse give	n in Part I.					ne cause of death?
l Rec	Ine law ate has b page 2 s	Completed									24a. Was a autop perfor 1 Yes	sy med?	prior to cor death?	psy findings available mpletion of cause of
ot	Attending Physicien: In it death. ector: Atter this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural	Hospital: 1 Impaties 28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of Injury		3c. Injury Work	or: 4 □ Nurs	sing Hon		ne) ence 6 □Oth ow injury occur		v)
=	i Žite o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	. (Specify	')				di	City or Tow	n, State)		i Route Number,
:	vithin 24 hours at To the Funeral C completely filled i	Medical	29a. Certifier (Check only one) 2 Medical Exami	sicien: To the best oner: On the basis of and manner sta	examinat:	ion and/or inv	estigation,	in my op	inion, death	occurre	d at the time, c	late and place,	and due to	the cause(s)
	- s + ó		30. Name and address of person who g	ompleted cause of de	eath_(Item_	,23a) (<u>T</u> ype, F	Print)	D 3	064	F-1	0 11	April 1	8 2	009
R.	Sta Registr		Ramesh Sabapal 31. Date filed (Month, Day, Year)	hi 201-10 R 2 0 2005	79 B	GCK K	wer.	Nec	k sla	ad_	150/11/1	Ped. Date signe April (More M	anyl	and

			1 - For State Registrar	State of I	Maryland / Dep Ce	artment o			iene eg. No. 2005	13370
П	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	h Day Year	3. Time of Death
	/Medi		Lillian		Jones	3		April.		10:20 P ^M
	Examir	ner	4a. Facility Name (If not institution, give		•		m, or Location of Death	1	4c. County of Death	
L			Kensington Nursi 5. Social Security Number 6. Se				nsington ear If Under 24 Hrs.	1	Montgo	
	Funeral Director			x □ M 2XXF /	Age (In yrs. last birthda) 94 Yrs.		ays Hours Min.	8. Date of Birth (Month, Day, Jan, 18,	Year) 9. Birth	place (State or Foreign ntry) ington D.C.
	p .		Usual Residence of Decedent					Jan. 10,		
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-1 show the Medical Examiner must be notilized at	Director	10a. State 10b. County Maryland Montgom 10e. Street and Number	ery	10c. City, Town or I	Si	lver Sprig			1 ☐ Yes 2☐ No
	3a or	i Dir	927 Gabel Court			10f. Zip Coo	20901	'	og. Citizen of What Cou United Stai	
	death ms 2	Funerai	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13	. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerlo	pecify Yes or No-	14. Race - Ameri	can Indian,
Baltimore, Maryland 21215-0036	ours after rel', or Ite Examine	by	1 📆 Never Married 2 🗆 Married 3 🗀 Widowed 4 🗀 Divorced	Armed Force 1 Yes 2 fif Yes, Give Year or Date	XNo	1 ☐ Yes 2 🔀		Hican, etc.)	Black, White, Specify: B1a	
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest grad		16a. Dec (Giv	edent's Usual Oc e kind of work do	ccupation one during most of work stired)	king	16b. Kind of Business/In	ndustry
121	ba filed within 72 ho ital Hygiene. id other than "netu event, Ire Medical	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	Homemal	•		Domest	ic
9	I filled I Hygi other ent, II	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M		
ılar	should ba and Mental s marked o umatic eve	To B	Simon Br	yant .	Jones		Louise	Reyr	olds Mo	onroe
lan			19a. Informant's Name/Relationship (7	= = =	19b. Mai	ling Address (Str	eet and Number or Ru	ral Route Number,	City or Town, State, Zip	Code)
≥, <	os 1 and 2 of Health of item 27 I	1	Alice Jenkins / F	riend		Gabel (ver Spri		
Jore	iges 1 at of H if ite or ot		20a. Method of Disposition 1XXX urial 2 ☐ Cremation 3 ☐		18	ematory or other	place)		20c. Location - City or To	own, State
Ē	it. Pa		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensia 				memtery 4/2		Suitland,	MD
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot		Star A. S.		M00382 8	app Fune	dress of Facility eral and Cr	emation	Services	1 20010
			23a. Part1. Enter the disease, or comp	lications that caus	ed the death. Do not er	33 GIST	dying, such as cardiac	er Sprin or respiratory arre	g, Maryland	Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition		e to the same of t					Onset and Death
	/Medical		resulting in death)		EISÍS as a consequence of):					7 days
	Examiner	<u>.</u>	Sequentially list conditions,	b	0					
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence of):					
Ć.	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequence of):					
8760,	ysicia ysicia	dicail		d						
9	rtifica ng ph as th	Medi	IF FEMALE:							
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death 3 at time of death 5	□Ectopic pregna □ Other (specify			23d. Date of delive Month	ery Day Year
σ.	res that igned b be deta	by Pi	Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
Records,	w require been sig should b	edb	Brain tumor, a	terial fi	ibrillation	, hypert	ension	1 ☐ Ye	s 2□No 3□Prob	pably 4 XUnknown
eco	e law requ has been je 2 shoul	Completed						24a. Was ar	24b. Were auto	psy findings available mpletion of cause of
Ě		Com						perform	ed? death? MANo 1 □ Yes	2 No
Vital	lcien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					h (Check only one		
	S S	2	1 ☐ Yes 2 ☐ ♣ o 27. Manner of Death	Hospital: 1 ☐ Inpa		TIL JUDON			nce 6 Other (Specific	y)
O	ding Phy h. After this funeral o	tion	1 √2 Natural 5 ☐ Pending	28a. Date of In (Month, E	jury 28b. Time Jay Year) Injury		njury at Work? I □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Division of	after death after death Director: A	fica	3 Suicide 6 Could not be	28e. Place of I	njury - At home, farm, s etc. <i>(Specify)</i>			28f. Location (Str	eet and Number or Rura	/ Route Number.
á	s after s afte	Certification:	4 Homicide determined	building,	etc. (Specify)	,,,,		City or Town,		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medicai (29a. Certifier (Check only one) 1 Medical Exami	sician: To the besiner: On the basis and manner:	of examination and/or in	th occurred at the	e time, date and place, ny opinion, death occur	and due to the ca red at the time, da	use(s) and manner as st te and place, and due to	tated. the cause(s)
	To t withi To tl comp	Σ	29b. Signature and title of certifier	1			ense number	-	d. Date signed (Month,	Day, Year)
	()		Amero	dest	Men. H.D	000	05763	0	April 19,	2005
	M		30. Name and address of person who can Anuradh Arun 103				ng MD 20902	2		
	Sta Registr	- 2	31. Date filed (Month, Day, Year)		trar's Signature	M. Se	relie			

			1 For		Maryland / Dep		lealth and M	lental Hygie	9005	13371
			Registrar	(ant)		Tillicate of	Deam	Rag.	No. U U J	10071
	Physici	an	Decedent's Name (First, Middle,	Last)	T			Date of Death Month	Day Year	3. Time of Death
	/Medic		NORA		Jaco			April	14 2005	8:00 p ^M
	Examin	ner	4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. County of Dea	ith
			Genesis Elder	care - Spa	Creek	Annap			Anne A	runde1
	Funeral				ige (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign ountry)
п	Director		325-16-0997	1 □ M 2/CXF	82 Yrs.	,		(Month, Day, Yea	1922 11	linois
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L					1
	aryla sho	-								10d. Inside City Limits
	Ba-f	ctc	MD Anne	Arundel	Crowns	ville				1 ☐ Yes 2XXNo
	if	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	23a	a	849 Rosewood T:	ail		2	1032		USA	
	eep E	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	cify Yes or No-	14. Race - Ame	
စ္	or th	正	1 ☐ Never Married 2 ☐ Marrie		No	_		nican, etc.)	Black, Whi	
8	raf',	1 by	3 ☐ Widowed 4XX ivorced	Year or Dates:	:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland liene. rthan "natural", or flams 23a or 28a-f show the Medical Examinar must be coullised at	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup	ation during most of worki	16b.	Kind of Business	/Industry
2	within ene. than	호	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	d)	,9		
21		ĕ		5+		apist		P	sycholog	у
b	be filed to tall Hygie of other to event, It	Be (17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Maid	en Sumame)	
<u>a</u>	Menta Menta arked	20	Frank Rosenberg	5			Sally l	Barnett		
Maryland	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationshi	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura		y or Town, State,	Zip Code)
	and 2 eaith a n 27 is		James Jacobs (S	ion)			Trail, Cro			
Baltimore,	- I E S		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	riari, Çiç		Location - City or	
2	permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2 【Cremation 3	☐Removal from State	3		I			
₽	rtme rtani njury		'4 □Donation 5 □ Other (Spe		Metro Ci			-2005 Bal	timore,	MD
32	permi Depa Impo any ii		21. Signature of Funeral Service Li	ienze-d	2	2. Name and Addres Hardests	ss of Facility Y Funeral	Home P.A		
	0.C. 2 to C.	A 17	10 0.	7		12	ely Avenue	. Annapol	is, MD 2	1401
н			23a. Pert1. Enter the disease, or conshock, or heart failure. List or	mplications that cause by one cause on each	ed the death. Do not en line.	ter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		D. slin	way 1	Burbul-	ίς	3	Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequence of):					1110
	Examiner									
		Je.	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Due to (or as	s a consequence of):					
	d d ansit	Ē	Cause (Disease or injury that initiated events						i	
Ć.	be executed ician and burial-transit	Examiner	resulting in death) Last	Due to (or as	s a consequence of);					
760,	icate be executed physician and s the burial-transit	cal								
89	ficate phy s the			u						
×	res that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnancy				2010-1-11	
Вох	atter for u	lar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
o.	the d	ysk	1 ∐ Yes 2 ∰ 10 9 ☐ Unknown	9☐ Unknown	at time of death 3					
۵.	hat ti	P.	Part II. Other significant condition	contributing to death	but not reculting in the co	adorbina anusa au	on in Don't	22a Did tabasa		the cause of death?
ŝ	ires t signe d be d	þ	and the other original contention	resimboling to death i	out not resulting in the u	riderlying cause give	en in Faiti.			
5	w requir been si should	ted						1 🗆 Yes	219No 311Pr	obably 4 Unknown
Vital Records,	4 2 C	Completed						24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
~	The ate h	PO						performed?	death?	2□ No
ā		Bec	25. Was case referred to medical				26. Place of Death		.0 .0.100	2010
	Attending Physician: The Ir death. actor: After this certificate haby the funeral director, page	To B	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 Inpati	ent 2 ER/Outpatier	nt 3 DOA Othe	AC	e 5 Residence	6 DOther (Spe	nifu)
<u></u>	eral eral		27. Manner of Death	28a. Date of Inju	ury 28b. Time of	f 28c. Injury	at 2	8d. Describe how in		ony)
Division of	tun fun	Certification;	1 Accident 5 Pending 2 Accident investigat	(Month, Da	ay Year) Injury	Work M 1□	(? Yes 2 ∐No		,	
S	dea dea ctor y the	ica E	3 ☐ Suicide 6 ☐ Could no	be one Blees of In	jury - At home, farm, str			8f. Location (Street	and Number or Ri	iral Route Number
2	or after Dira	i i	4 Homicide determine	building, e	tc. (Specify)	oot, radiory, omoo		City or Town, Sta	te)	a riosto i varioci,
_	To tha Hospital or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	2	29a. Certifier 1 Certifying	Ohyeicien: To the hear	of my knowledge death	a control of the co	no doto and its	ad duo te the	a) and	
	Fun Fun	edical		aminer: On the basis	of my knowledge, death of examination and/or in-	vestigation, in my or	ie, date and place, a pinion, death occurre	d at the time, date a	s) and manner as nd place, and due	to the cause(s)
	thin ;	Mec	29b. Signature and Tille of certifier)	and manner st	lateu.	200 Lines	number	004.5	ata signed /44s	Day Vand
	Z 2 6		255. Signature and tipe of certifier	. 10		Zac. License	18.26	290. 0	ate signed (Mont)	
		V	13 410	eun,		40	0 00	7	1181909	7
1	1		30. Name and address of person wi	o completed cause of	death (Item 23a) (Type,	Print)		1	(/	
Y	10		Goy J of	vore a	death (Item 23a) (Type,	Jorah Di	me the	rein 2	1619	
	Stat		31. Date filed (Month, Day, Year)	32. Registi	rar' Signature	1.1.	_			
	Registra	ar	APR	2 0 200	Blecux S.	PROBALL				

	an	Decedent's Name (First,	Middle, Last	,		Gertificat 25705				2. Date of Do Month	Day		ear	3. Time of Deat
/Medi		Terri	Lyı			Kaline				April '		2005		10:45 A
Exami	ier	4a. Facility Name (If not inst 321 Lorraine)		Town, or t		f Death		4c.	. County of		
		5. Social Security Number	6. Se		ge (In yrs. last birth		ESSEX	If Under 2	4 Hrs	9 Date of Bi	i de la	Balti		
uneral irector		216-46-8809 Usual Residence of Decede	1 [rs. Months		Hours	Min.	8. Date of Bi (Month, Di ebruary	av. Year)	960	Counti	MD.
MOL.		10a. State 10b. Co			10c. City, Town	or Location							10	d. Inside City Lin
a-f s	ctor	MD. Ba	ltimo	re	Es	sex								1 ☐ Yes 2 💢
itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant. I'm Mudical Evantrar must be notified at	Funeral Director	10e. Street and Number 321 Lorraine	Avenu	ıe		10f. Zip	2122	1				izen of Wha	at Counti	y?
ams a	ner	11. Marital Status		12. Was Decedent Armed Forces	t Ever in U.S.	13. Was Deced	dent of His	panic Orig	in? (Spe	cify Yes or N	0-	14. Race -		
rai', or its	by Fu	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 🛣 Dive		1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes		Specify:	Puerto i	rican, etc.)		Black, Specify:	White, e	
marked other than "natural",	Completed by	15. Dec (Specify only I Elementary/Secondary (0		lication le completed) College (1-4or	(Decedent's Usua (Give kind of wo life. DO NOT us	al Occupat ork done du ise retired)	tion uring most	of workin	ng	16b. Ki	ind of Busir	ness/Indu	istry
4 3	mo.	12 years	12)	College (1-40)		ounseloi	r				Gro	oup Ho	ome	
oth	Be (17. Father's Name (First, Mi					1	18. Mother	's Name	(First, Middle	, Maiden	Sumame)		
arka atic a	ြို	Paul Shaffer	Jr.				1	Mary	V. I	ongene	ecker			
am 27 is muther traum		19a. Informant's Name/Rela Paul Shaffer		_(рв, Print) Brothe		Mailing Address 78 St. N								Code)
f itam r othe		20a. Method of Disposition			20b. Place of I	Disposition (Nan	me of		_	^{ate} 21,		ocation - Cit		n, State
int: If		1 ☐ Burial 2 🛱 Crema 1 ☐ Donation 5 ☐ Oth				v Cremat			2005		Balt	imore	Cit	TV MD
Important: If itam any injury or othe once.		21. Signature of Funeral Se				Connel	d Address	of Facility unera	l Ho	ome Of	Dund	lalk,P	.A.	
		23a, Part1, Enter the diseas	e, or compl	ications that cause	per dvr		<u> мате</u>			Road,		aık,™	D, Z	1222
		snock, or near failure.			u ine death. Do no	ot enter the mod	e of dying,	such as c	ardiac or		rrest,		1	Approximate
sician		Immediate Cause (Final	List only or	ne cause on each	no the death. Do no	ot enter the mod	de of dying,	such as c	ardiac or		irrest,	f	1	nterval Between Onset and Death
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			For State Registrar	State	of Marylar		artment of H <i>tificate of L</i>				giene Reg. No. 2	005	13373
			1. Decedent's Name (First, Middle, I	ast)				-		2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		Erdice Almeda							April 1	6, 20	05	*7:50 AM
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, or					unty of Deat	th
_			Millenium Heal 5. Social Security Number 6.	Sex Kei	1ab 7. Age (In yrs.	last hirthday)	Ellicot			8 Date of Birth		ward	hplace (State or Foreign
	Funeral Director		414-44-5765	1 □ M 2 🌣 F	88	Yrs.	Months Days	Hours	Min.	8. Date of Birth 10/13/1	916	Co	ountry).
	ס		Usual Residence of Decedent										
	arylar show	2	10a. State 10b. County		10c. Ci	ity, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 No
	he M	Director	Maryland Howard 10e. Street and Number			ETT	icott Cit	tу			10a Citizon	of What Co	
	Mith Mith	i Dir	3113 Ramblewood	Rđ.			2104	42				ed Sta	•
	ms 23	era	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba		igin? (Spe	city Yes or No-		Race - Ame	rican Indian,
٥	or ite	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed F 1 ☐ Yes If Yes, G	2 No	,	f Yes, specify Cuba I□ Yes 2 Ho	ın, Mexicar Specify:		Rican, etc.)		Black, White ecify: Wh	e, etc. lite
9500-61212	hours after death with the Maryland turei', or Items 23a or 28a-f show al Exactingt must be collined at		3 Nidowed 4 □ Divorced	Year or I	Dates:							ecny.	
ָה ה	"nati	Completed	15. Decedent's (Specify only highest of	Education rade completed)		16a. Deced	lent's Usual Occupa kind of work done o DO NOT use retired	ation during mos	t of worki	ng	16b. Kind	of Business/	Industry
7	within then then	ошо	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		emaker	7			Owi	n Home	2
	Hyg other	Be C	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle,	Maiden Su	mame)	
yland	uld be Menta rrked rric ev	To B	Carl Nathaniel	Jones				E	ffie	D. Brow	wn		
Mary	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the Transted other then "nature!", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship		1 1 - 4		g Address (Street a						
	and lealth m 27 her tr	1	Virginia Elaine	Keary(c				ood R					
altimore,	ges 1 If ite or oti		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3		State Ha	cemetery, cren milton	sition (Name of natory or other plac Memorial S	e)		ate		ion - City or	
	it. Pa intmen intent: njury		'4 □ Donation 5 □ Other (Special Service)										nessee
g	permit. Pages Department of I Importent: If Ite any injury or or once.		21. Signature	#TIS00	M01290) 1	Name and Address itzke fur 630 Edmor	ieral idson	Home Ave	e of Cat	tonsv:	ille, le. MD	Inc. 21228
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that	caused the dea							20, 120	Approximate Interval Between
	Pnysician-		Immediate Cause (Final disease or condition	y one cause on		me	nta						Onset and Death
	/Medical		resulting in death)	aDue to	(or as a conse	-	, ,,,						
	Examiner		Sequentially list conditions,	b									
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):							
	xecut and	Examine	that initiated events resulting in death) Last	c	(or as a conse	quence of):							
8/6U	death certificate be executed e attending physician and ad for use as the burial-transit	dlcal		d									
٥	tificati ig phy as the	ledic											
X Q Q	that the death certificated by the attending properties as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		Ectopic pregnancy				23d	. Date of deli	
	e dea the at	sicl	in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	4□Preg 9□Unkr	nant at time of o	death 5	Other (specify)					Month	Day Year
Į.	requires that the reen signed by th hould be detache		Part II. Other significant conditions	contributing to c	leath but not re	sulting in the w	nderlying cause give	en in Part I		23e. Did to	bacco use	contribute to	the cause of death?
ds,	w requires that s been signed b should be deta	d by	Blad	dar C	Α		Tuony mg tuoto grit				es 2□N		1
Hecords	> 00	ompleted								24a. Was a	n 2	4b Were au	itopsy findings available
Ě	has ye 2	дшс								autops perfor	sy	prior to death?	completion of cause of
VITAI	iclen: Th certificate rector, pag	e C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only or	ne)	1 LJ Yes	2 No
	di is	To B	examiner?	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA Othe	er l		ne 5 ☐ Resid		Other (Spec	cify)
n or	ding Phys		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. Injury Work	/ at k?	2	28d. Describe h	ow injury o	ccurred	
S S	Attending ir death. ector: After by the fune	catle	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he				Yes 2					
VIVISION	or Attendate death Director:	Certification;	4 Homicide determine	28e. Plac	e of Injury - At I ling, etc. (Speci	iome, tarm, str ify)	eet, factory, office		4	City or Town		umber or Ru	iral Route Number,
_	spitei ours a nerei		29a. Certifier Certifying	Physician: To th	e best of my kn	owledge, death	occurred at the tim	ne, date an	id place, a	and due to the c	ause(s) and	d manner as	stated.
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Ex	aminer: On the I	pasis of examin ner stated.	ation and/or in	estigation, in my or	pinion, dea	th occurre	ed at the time, d	late and pla	ice, and due	to the cause(s)
	To the within 2 To the complet	3/	29b. Signature and title of certifier	- DA	J. J. 7	MC	29c. License	number	-	2	9d. Date si	igned (Month	h, Day, Year)
_	10		Kithan	XKIM	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	3 1712	1772	272	5		71	16/0	5
1	21		30. Name and address of person w	mpleted cau	se of death (Ite	m 23a) (Type,	Print)	CE	. ا. م	nac 1	010	1011	2,21228
			31. Date filed (Month, Day, Year)	an hand	Registrate Sign	ature	Joseph	17 T	600	real	1-4 3	1110	1000
	Sta Registr		APR	2 0 2003	place								

JET 05-02615 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amber Boothe-Lowe State of Maryland / Department of Health and Mental Hygiene () 5

1- State Amend Item 17 per fh G842 4-20 05 in the State of Death

Reg. No. UNK Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Amber Marie Lowe 2005 April 7:00 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2800 Indian Drive Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Director 220-11-7721 Yrs. 26 8-25-78 MD Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 230 215 Pinewood Rd. Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 ☐ Never Married 2X Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced "neturel', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within. Health and Mental Hygiene. em 27 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Sam Ray Boothe <u>Anna Maria Herman</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 la 215 Pinewood Rd. Dundalk MD 21222
and Disposition (Name of Date 20c. Location - City or Town, State Robert Lowe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If eny injury or = 5 Bayview Crematory 4-21-05 Dundalk, MD 22. Name and Address of Facility Wesley Chavis Jr. FH 21. Signature of Funeral Service Licenses 2007 Eastern Ave, Balto, MD 21231 23a. Parh. Enter the disease or complications the shock, or heart failure List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cunshot wound /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 Live birth jo in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. page 2 should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 24a. Was an autopsy performed? 1☑ Yes 2□No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ KOther (Specify) Scene 2 1X Yes 2 □ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Subject Shot

28f. Location Street and Number or Rural Route Number,
City or Town, State)

2800 Indian Priver A death. investigation 1 ☐ Yes ZNo 2 Accident Director: 6 Could not be determined 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide found in wolf course pune 2600 Inducant Drawt no 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funerel L 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) OCME NO April 14 2005

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

bero

2005

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

APR 20

Elsen H. Spell **ORIGINAL**

111 Penn Street

Baltimore, Maryland 21201

			1 - For State Registrar	State of Maryla		artment of He				
			Registrar 1. Decedent's Name (First, Middle, Last	1	Cel	illicate of D	eaur	Reg	200 E	3. Time of Death
	Physici	an			ewer, J	r		Month	, 2005 Year	
	/Medic		4a. Facility Name (If not institution, give		ewer, o	4b. City, Town, or L	ocation of Death		4c. County of Dea	
	Examir	ier	Stella Maris			Timoniu			Baltim	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Ri	rthplace (State or Foreign
	Director		217-24-7642	M 2□F	77 Yrs.	Months Days	Hours Min.	May 28,		ountry) arvland
	P _		Usual Residence of Decedent							
	arytai show	_	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
	88-f	ç	Maryland Baltimor	'e	Timoniu					
	vith th	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ountry?
	s 23s	Funerai	518 Wyngate Road		110 100	21093			U.S.A.	adaa tadaa
	ltem Item	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?		Was Decedent of Hist f Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	3 Widowed 4 Divorced	1XXves 2 □ No If Yes, Give 1945 – Year or Dates:	1947	I□Yes 2☐XNo	Specify:		Specify:	hi+a
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28e-f show fra Madical Examiner must be multified at		15. Decedent's Edu		16a. Deced	lent's Usual Occupati	ion	16	Sb. Kind of Business	hite
75	nin 72 in "in Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	ring most of worl	king		,
7	d with	E	12	Oblige (1-401 54)	E.	ngineer		-	Telephone	Company
	othe	Bec	17. Father's Name (First, Middle, Last)				8. Mother's Nam	e (First, Middle, Ma		
Maryland	uld b dents rked rice	To E	Carroll Emmitt Lo	ewer, Sr.			Ida	May Rin	nehart	
ar	and has ma		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	g Address (Street an	d Number or Ru	ral Route Number, C	City or Town, State,	Zip Code)
	and 2 salth n 27		David C. Loewer	Son		Ash Stree	t Bal	timore, Ma	aryland	21211
ore	of He		20a. Method of Disposition 1 XBurial 2 Cremation 3 F		 Place of Dispo cemetery, crer 	sition (Name of natory or other place)			c. Location - City of	
Ĕ	Pag nent ent: I		`4 ☐Bonation 5 ☐ Other (Specify)		rkwood (Cemetery	4-20-	-2005 Pa	arkville	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23a or 28e-f show any injury or other treumatic event, It a Madical Examiner must be notified at once.		21. Signature of Tunanti Service Licens	e 6	22	. Name and Address	1/1			Home, Inc.
_	70 F # 0		Taul W	Hagan		1050 York			Maryland :	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	ications that caused the de ne cause on each line.	eath. Do not ent	er the mode of dying,	such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Physician	2 4	Immediate Cause (Final disease or condition resulting in death)	BLADDER CA	NCER					
П	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
ł		.	Sequentially list conditions,	Due to for as a cons	equence of					
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	530 15 gai 40 4 55119	agains ag					
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					- 17
8760,	ficate be executed physician and s the burial-transit	dicai		1						
89	ificati g phy as the	edic								
Вох	death certific e attending p id for use as	M/N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg 1□Live birth 2□Fe		Estania arasanana			23d. Date of de	livery
m m		icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	The law requires that the death sie has been signed by the atter page 2 should be detached for r	by Physician/Me	9 🗆 Unknown	9 Unknown						
	es tha igned be de	by P	Part II. Other significant conditions con	ntributing to death but not r	esulting in the ur	iderlying cause given	in Part I.	23e. Did tobac	cco use contribute to	o the cause of death?
pic	w requir been si should I							1 ☐ Yes	2 □ No 3 □ P	robably 4XUnknown
S	e taw ra has be je 2 sh	pie						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
ř		Completed						performe 1 ☐ Yes 2 X	d? death?	2 □ No
Vital Records,	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					h (Check only one)		
oto	\$.s =	္င	1 ☐ Yes 2 X No	lospital: 1 ☐ Inpatient 2		3 □ DOA Other:	4 🗌 Nursing Ho			ecify) HOSPICE
<u>_</u>	ding Ph h. After th funeral	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe how	injury occurred	
<u> </u>	Attending in death. ector: After by the fune.	cati	2 Accident investigation 3 Suicide 6 Could not be				s 2 No			
Division	after death after death Director: I in by the	ertification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
_	pitel ours a erel [0	29a. Certifier 1X Certifying Physical Certification	sician: To the heat of multi-	nowledge doct	occurred at the time	date and size-	and due to the asset	co(e) and ma	e stated
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical		sician: To the best of my k ner: On the basis of exami and manner stated.						
	o the	Me	29b. Signature and title of certifier			29c License n	umber	29d.	. Date signed (Mont	h, Day, Year)
	- s - ō					1 DL	3771		4/18	105
	24		30. Name and address of person who co	empleted cause of death (It	em 23a) (Type, I	Print)	0 , 00		1/10/	
	2011		DR. TARIQ MAHMOO				IMONIUM	MD 2109	3	
	Sta	te	31. Date filed (Month, Day, Year)			Sparke				
1	Registr	ar	APR	2 0 20 0 5 <i>Sea</i>	Eur D	To the same				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 18, Day 2005 Year Long Agnes Elizabeth 4:25 p M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Broadmead Cockeysville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Year) 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday)

10f. Zip Code

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

21286

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10d. inside City Limits

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

U.S.A.

1 Yes 2 No

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-f show any Injury or other treumatic event, Item Modical Externing It was be inclined as Baltimore, Maryland 21215-0036

1 - State Registrar

191-18-9577

10e. Street and Number

10a. State

MD

11. Marital Status

Usual Residence of Decedent

1031 Metfield Road

1 ☐ Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

1 ☐ M 2 🗓 F

Baltimore

15. Decedent's Education if only highest grade completed

81

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

10c. City, Town or Location

Towson

Physician

/Medical

Examiner

Director

Funeral

Director

/Medical **Examiner**

Physician the attending physician and thed for use as the burial-transit within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fur

D C	Classical (Case of a 10 10)	College (1.1 a. 5.)	life. DO NOT use retired	d)			
Be Compi	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker			Own home	2
9	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	First, Middle, Maide	эл Sumame)	
ToB	Francis	Luczak		Frances	5	Wislows	ki
	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Street	and Number or Rural F	Route Number, City	or Town, State, .	Zip Code)
	F. David Hollowa	y-son	P.O. Box 15	59, Easton	, MD 216	501	
	20a. Method of Disposition	00	ace of Disposition (Name of	Date	e 20c.	Location - City or	Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	rey Valley Mem'l G		5 Ti	imonium, MI	
	21. Signature of Funeral Service Licent	see William G. Dau	22. Name and Addre	ss of Facility Ruck	: Towson Fu	neral Homo	Tre
	Mulh		1050 York	Rd., Towson,	MD 21204		, 110.
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death	. Do not enter the mode of dyin	ig, such as cardiac or r	espiratory arrest,		Approximate Interval Between
	Immediate Cause (Finat disease or condition	BREAST	CARICE	P			Onset and Death
	resulting in death)	Due to (or as a consequ	ience of):	1			
		BRAIN	METAS-	TASES			
er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of):				
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events						
Exa	resulting in death) Last	Due to (or as a consequ	ence of):				
ai		d					
edic		<u>. </u>					
Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar				23d. Date of del	livery
ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		,		Month	Day Year
Completed by Physician/Medical Examiner	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown					
/P	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
d b					1 ☐ Yes	2	obably 4 Unknown
ete					24a. Was an	Odb Woss s	dens. Cadinas austable
mp					autopsy performed?	prior to death?	stopsy findings available completion of cause of
S					1□ Yes 2☑N		2□ No
Be	25. Was case reterred to medical examiner?	Unacitals		26. Place of Death (C	Check only one)		
To	1 192 7 100		ER/Outpatient 3□ DOA Oth	4 12 Nursing Home			cify)
on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Injury Work	K?	I. Describe how inj	ury occurred	
cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Yes 2□No			
ŧ	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, street, tactory, office	· 28f.	Location (Street a City or Town, Sta		ural Route Number,
Ce							
Medical Certification: To Be	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	vsician: To the best of my know iner: On the basis of examinati	vledge, death occurred at the tin	ne, date and place, and pinion, death occurred	I due to the cause(s) and manner as	stated.
ledi	one)	and manner stated.					
2	29b. Signature and title of certifier	C	29c. Licens	e number	29d. D	ate signed (Month	h, Day, Year)
	Darbara	arroll	12) 1	58578	7	1/8/2	2005
	30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, Print)	/4 D 2 4 D 7	\)) .	
	BARBARY CA	KKOLL, M.	U., 13801 V	DKK KL	1., COCK	EYSU	IUE, MD
te	31. Date filed (Month, Day, Year)	32 Begistraes Signati	ure of Angel			-/	
ar	ALL Y	, o Loop Justice	/				

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar			artment of Health ar rtificate of Death	Reg	ene . No.2005	13377
	Physici /Medi	cal		LINTON LYL	ES	di On Turning de			3. Time of Death 2:30 A M
	Examir Funeral	ner		MEDICAL CE	NTER (In yrs. last birthday)	4b. City, Town, or Location of BETHESDA If Under 1 Year If Under 24	Hrs. 8. Date of Birth	4c. County of Death MONTGOM 9. Birth	
	Director		406-20-2590 Usual Residence of Decedent 10a. State 10b. County	1 X M 2□F	78 Yrs.		Min. (Month, Day, Y Aug. 22,	1926 Kei	ntry) 1tucky 10d. Inside City Limits
	ath with the Marylans 23a or 28a-f show	Director		runde1	Harwood		100	. Citizen of What Cou	1 ☐ Yes 2 X No
	leath with ns 23a or	Funeral Dir	4609 Solomons I	sland Road	ver in U.S. 13.	20776		USA 14. Race - Amer	
036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show Jisal Exarti wat be redified at	by	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates:	0	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	Puerto Rican, etc.)	Black, White	
21215-0036	within ne. Ihan "	ompieted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most o DO NOT use retired) Petty Officer	f working	b. Kind of Business/Ir	ndustry
	be filed tal Hyg d otha evant,	o Be Co	17. Father's Name (First, Middle, Last Jewel Clinton I		Curer	18. Mother's	Name (First, Middle, Ma. Dalton	.S. Navy iden Sumame)	
, Maryland	nd 2 sh alth and 27 is m r traum	-	19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street and Number of Solomons Islan	or Rural Route Number, C	•	
Baltimore,	000		20a. Method of Disposition **Burial 2		Lakemont	Mem. Gdns 4-	-21-2005 D	c. Location - City or T avidsonvi1	
Ball	permit. Pag Department Important: b any injury o		21. Signature of Euneral Service Ato	SSEE		Name and Address of Facility Hardesty Funera 12 Ridgely Aver	ue, Annapol	is, MD 214	
200	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line NON a).	L LUNG CANCER	rdiac or respiratory arrest	11.	Approximate Interval Between Onset and Death
,	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncompany Cause (Disease or injury that initiated events resulting in death) Last	С.	consequence of):				
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.O. Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause given in Part I.		co use contribute to t	
I Record	The ate h page	Completed					24a. Was an autopsy performed 1 ☐ Yes 2€	prior to co death?	ppsy findings available impletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital: X		Out -	Death (Check only one)		
of	shysi this c	2	1 ☐ Yes 2 ☐XXX	1 Zinpatien	-		ng Home 5 Residence		(y)
Division	ding h. After fune	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	00 - Bloom of Injur	Year) 28b. Time of Injury	28c. Injury at Work? M 1 Tyes 2 No		injury occurred It and Number or Rure	al Boute Number
Dİ.	To the Hospital or Attan within 24 hours after deat To tha Funaral Diractor: completely filled in by the	O	4 Homicide determined	building, etc.	(Specify)	n occurred at the time, date and p	City or Town, S	itate)	
)	To the Ho within 24 h To tha Fur completely	Medical	(Check only one) 2 Medical Example Medical Example 29b. Signature and title of certifier	miner: On the basis of and manner state	amination and/or in	vestigation, in my opinion, death	occurred at the time, date	and place, and due to Date signed (Month,	o the cause(s)
)	5 With	1	· Jodd	La Row	0.0.	0102201465	(VA)	4/18/-5	
K	2/6/		30. Name and address of person who TODD R. LAROC	K LCDR MC	USN	BETHESDA	NAVAL MEDIO MD 20889-50		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar 2085	's fignature	: Special			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 1 tems 7.8 per 1h 8842 4-22-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** $3:00_a^{M}$ WILLIAM LITTLE APRIL /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CENTER TOWSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth Hours | Min. | State of Birth | 1934 | 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1**X**M 2□ F 70 245 46 1851 72 Yrs. Director JULY 10, 1936 N. CAROLINA Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at MD 1 Yes 2 □ No Director N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 WEST BALTIMORE STREET 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th CRANE OPERATOR BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDMOND DAVIS CARRIE LITTLE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If Item 27 Is STEVEN LITTLE (SON) 9107 BALDRIDGE WAY ROSEDALE, MARYLAND 21237 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APRIL 22, 2005 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST CEMETERY OWINGS MILL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician KLebsiella phermonia weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 0515 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel within 24 hours a To the Funerel E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chales St. Balto . md ł۷ 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 2 0 2005

			For State Registrar	State of N	Maryland /		ırtment <i>tificate</i>			and M		giene Reg. No.	2005	13379
	Dharaisi	2	1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		DREXEL M.	DAVIS	McMURRAY	Ζ					April	16	2005	11:50p M
)	Examin		4a. Facility Name (If not institution, give	street and numbe	er)		4b. City, T	own, or	Location o	of Death		4c. (County of Dea	ith
	物	X .	HCR MANOR CARE-ROI				BALT						N/A	
* .	Funeral		5. Social Security Number 6. Sex	7 M 2 XCX F	Age (In yrs. last i	Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day	y, Year)	C	thplace (State or Foreign ountry)
	Director		216-12-7895 Usual Residence of Decedent		89	115.					Dec. 1	1915	M	ARYLAND
	land		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	Many	tor	MARYLAND N/A			BAT.7	IMORE	1						1 X Yes 2 ☐ No
	28a	Director	10e. Street and Number			D1111	10f. Zip C					10g. Citiz	en of What C	ountry?
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121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4d			OO NOT use						,	
	be filed within 72 hours after death with the Marylan Ital Hygliene. Id other than "neturel", or litems 23s or 28s-1 show event, the Medical Evander from the Legisliked at		unknown 17. Father's Name (First, Middle, Last)		\$01	PERV	SOR O)F, A			ERICA (First, Middle,		/A	
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Ž	d 2 should be th and Menta 7 Is marked traumatic ev	P _C	SPRY RICHARD DAY 19a. Informant's Name/Relationship (Ty		1	Qh Mailin	n Address /	(Street a			I Route Numbe			Zin Code)
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no			1 XX urial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from Sta	ite		natory or oth			4 07	0.5	D 3 T III	THORE	WI DITT THE
Baltimore,			21. Signatur Ingral Line Licens	99	KING		ORIAL . Name and			4-21 v				MARYLAND
Ba	permit. Departr Importe eny inju		- They	mus	n	W 1	ILLIAM 206 W	ICI NOR	BROWN TH AV	COM	MUNITY	FUNE	RAL HO	ME P.A.
	* *		23a. Part Enter the disease, or compl	cations that caus	sed the death. D						r respiratory ar	rest,		Approximate Interval Between
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on eac	1 lb 1 .	4 15.	(CKI	(22	Co	mc0-			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or	as a consequenc	e of):		- 00	V ()		mels			
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o.	at the de by the a tached	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknowr			outer (ope	J.,						
٣.	that ned by deta		Part II. Other significant conditions con	ntributing to deatl	h but not resulting	g in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco us	e contribute t	o the cause of death?
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Vital		Ö	25. Was case referred to medical						26. Place	of Death	1 Yes	2⊟No ne)	1 10:	5 2 100
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l of		n: T	27. Manner of Death	28a. Date of I		Time of		lc. Injury Work		_	28d. Describe h			,
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Division	lor Atte atter des Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of building.	Injury - At home, etc. (Specify)	farm, str	eet, factory,	office		1	28f. Location (S City or Tow		Number or A	lural Route Number,
	itel or A rs atter el Direc led in by	Cer			,,,									
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	the hin 24	Medicai	one)	and manner										
	To To	-	29b. Signature and title of certifier	2		MN	290.	T	number	1		_JU. Date	DIGITIES (MICH	th, Day, Year)
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	9		30. Name and address of person who co	mpleted cause of	or death (Item 23:	a) (Type,	Print)	(24	TAG) -	St for	to 3	80	Salt MP
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	istrar's Signature	die	K P	- 0(, , , , , ,		-4 0770	~	J W	2/65
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #4a-c PER PHY C849 rtificate of Death 2. Date of Death Month 55 PM **Physician** 12. 2005 oma /Medical 4b. City, Town, or Location of Death 4c. County of Death (If not institution, give street and number) Examiner HARFORD GARDEN NURSING HOME BALTIMORE 7. Age (In yrs. last birthday) Yrs. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 20-05-5811 **Director** Usual Residence of Decedent 10a. State Od. Inside City Limits 10b. County City, Town or Location or items 23a or 28e-f show artment of Health and Mental Hygiene. orient: If item 27 is marked other then "naturel", or items 23s or 28e-1 shov injury or other traumatic event, the Medical Examinar musit be rediffed at 1 Pes 2 □ No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 ence Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ${\cal B}$ Specify Be Completed by Yes, Give 'ear or Dates: jac 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) da y (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Pages 1 and 2 should be nent of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, 9a. Informant's Name/Relationship (7 20c. Location Vethod of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Importent: permit. 21. Signatur Funeral Service Licensee any Eun W. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 4 Unknown 1 Tyes 2 No 3 🗍 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 Ø No 24a. Was an certificate has autopsy performed? 28 No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funerel D Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier 0 6 3 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) 60 do c 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Meyon

		1 - For State Registrar 1. Decedent's Name (First, Middle,		-	epartment Certificate		2, Date of De	Reg. No.2	005	3. Time of Death)
Physicia	an	Woodrow Mc	•				Month	Day	Year		
/Medic		4a. Facility Name (If not institution,		r)	4b. City, To	own, or Location of Dea	APRIL		2005 ty of Death	6:34 PM	-
_Aum	Ŭ	SINAL HOSPITA	L OF BALT	IMORE	RAL 1	TIMORE C	ITY	N/	Α		
Funeral	- 1	5. Social Security Number	6. Sex 7. A 1 → M 2 □ F	Age (In yrs. last birt	hday) If Under 1	Year If Under 24 Hi Days Hours Mi	n. 8. Date of Bir (Month, Da		9. Birth	place (State or Foreign ntry)	
Director		247-48-2564 Usual Residence of Decedent	* -	73	115.		May 7,	1931	S. C	arolina	-
how		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits	
ns 23a or 28a-f show must be nutified at	cto	Maryland N/	A	Balt	imore					TX Yes 2 □ No	_
The n	by Funeral Director	10e. Street and Number 3507 Spaulding	a		10f. Zip C	215		10g. Citizen o		ntry?	
anither name	hera	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was Decede	nt of Hispanic Origin? y Cuban, Mexican, Pue	(Specify Yes or No	- 14. R	ace - Ameri		-
	Fui	1 Never Married 2 Marrie	Armed Forces ad 1 Tyes 25 If Yes, Give] No	1 ☐ Yes 12€		erto Hican, etc.)	Spec	lack, White,	etc. lack	
	d b	3 ☐ Widowed 4 ♣ Divorced	Year or Dates								_
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marked matic e	2	Samuel McFado				Dosh				UNK	R
traum		19a. Informant's Name/Relationsh Shirley T. Su		ughter	Mailing Address (:	Street and Number or I	Rural Route Numb	er, City or Tow 2	n, State, Zip	Code)	
Important: If tiem 2/1s marked other than any injury or other traumatic event, IDE M. once.	1 3	20a. Method of Disposition		20b. Place of	Disposition (Name y, crematory or oth		Date	20c Location	or a l	Md 21213 own, State	-
ry or		Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from Stat ecify)	Mt. Z	ion Cem	etery 4/2					
any injury or once.		21. Signature of Funeral Service L								_	
들점		Bury 9	tarris						ore,	eral Home	
.>		23a. Part Enter the sease, or contact k, or heart ailure. List of	complications that cause only one cause on each	ed the death. Do n line.	ot enter the mode	of dying, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
cian lical		Immediate Cause (Final disease or condition resulting in death)	_ a _ SEP							I WEEK	_
niner		i i	5,000,000	s a consequence o	economic so) (C F & C F				> 1 VEA0	
	ner	Sequentially list conditions, if any, leading to immediate nations and the sequence of the seq	b. Due to (or a	STALE is a consequence of	NENAL I	DENDE				> YEAR	-
transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o. CORO	NARY AR	TERY D	ISEASE				210 YEARS	_
burial	cal E	Totaling in doubly bust		s a consequence o	•					NO VOLO	
attending physician and for use as the burial-transit			dDIVIP	TES ME	11111				/	10 YEARS	•
e esn.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Fetal death	3 ☐Ectopic prec	TD 2 D C L		23d. E	ate of delive	,	
detached for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 ☐ Other (spec			, A	Month	Day Year	
detach		9 ☐ Unknown Part II. Other significant condition	as contributing to death	but not resulting in	the underlying cau	se awen in Part I	23e Did t	obacco use co	ntribute to th	he cause of death?	
pe	d by	,	To do a do a do a do a do a do a do a do	out not recalling in	ino anaony nig oac	so givon in rain.				pably 4 Munknown	
should	Completed						24a. Was	an 24b	. Were auto	ppsy findings available	
ector, page 2	ошр						autor perfo	rmed?	prior to co death? 1 \(\sum \text{Yes}	mpletion of cause of	
	0	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only o	2XNo	1 1 1 1 1 1 1 1 1 1	22140	-
ral director,	ToB	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🔀 Inpa			Other: 4 Nursing	Home 5 ☐ Resi	dence 6 □0	ther (Specif	ý)	
nue	inol	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. T Day Year) Ir	njury	. Injury at Work?	28d. Describe	now injury occi	urred		
the	icat	2 Accident investigated as Suicide 6 Could not	ot be	njury - At home, far	M street factory	1 Yes 2 No	28f. Location (Street and Nur	nber or Rura	al Route Number,	
d in by	ertif	4 Homicide determin	building,	etc. (Specify)	m, sneet, ractory, t	Silice	City or To		iber of Fiera	i riodia rambar,	
y fille	Salc	29a. Certifier 1 Certifying	Physicien: To the bes	st of my knowledge	, death occurred at	the time, date and pla	ce, and due to the	cause(s) and r	nanner as s	tated.	-
11 0	Medical Certification:	one)	xeminer: On the basis and manner:				curred at the time,				_
the I	2	29b. Signature and title of certifier	11.		29c. I	License number		29d. Date sigr	ed (Month,	Uay, Year)	
completely filled in by		/ W / I	11 / /		i						
To the Funeral Director:		30. Name and address of person w	the contributed asset of	MD		RES-000		APRIL	11. 90	105	-

DHMH 17 Rev 1/2001

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	Dhusia		Registrar 1. Decedent's Name (First, Middle)			Certificat	e or t	Deali		2. Date of D Month	eath		3. Tim	e of Death
	Physic /Medi		Lisa Donita 1							Apri1	Day 09	Year 2005	9:5	7 P M
	Exami	ner	4a. Facility Name (If not institution	. 3	•	4b. City,		Location			4c. C	ounty of Death		
<u></u>	Funeral	7	3019 Clifton A 5. Social Security Number		tment 2 Age (In yrs. last bil	nthday) If Under	Balt 1 Year	imore		8. Date of Bi	rth	N/A	alana /Cta	ite or Foreign
9	Director		216-36-7123	1 □ M 2 🛣 F	38	Monthe	Days	Hours	Min.	10-14	ay, Year) -66	MD	ntry)	ile or Foreign
D	pu »		Usual Residence of Decedent 10a. State 10b. County		10. Cit. T.									
	Aarylan I show ed al	5			10c. City, Tow]		e City Limits
	the M 28a-f	Director	MD 10e. Street and Number		Balti	LMOre	Code				10a Citiza	en of What Cour		
	or death with the Maryland tems 23a or 28a-1 show for must be notified at		3019 Clifton	Avenue A	pt.2		2121	7			-	or what coul	iti y :	
	ter death v Itams 23a	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13. Was Deced			igin? (Sp	ecify Yes or N	USA 0- 14	. Race - Americ		١,
36		by Fu	1 Never Married 2 ☐ Mar	ried 1 □ Yes 2 X If Yes, Give] No	1 🗆 Yes		Specify:		nican, etc.)		Black, White, pec <i>ify:</i> Bla		
Ö	within 72 hours after ane. than "natural", or Ita		3 ☐ Widowed 4 ☐ Divorced	Year or Dates t's Education		. Decedent's Usua	N Occupa	ation						
215	nin 72 in "na Wedic	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed)		(Give kind of wo life. DO NOT us	rk done o	turina mos	st of work	ring	160, Kind	d of Business/In	dustry	
21,	od with	Som	10th	College (1-4o		ırsing					Resi	denta	L	
Maryland 21215-0036	2 should be filed within 72 hours aft and Mental Hygiene. Is marked other than "natural", or aumetic event, the Medical Exernation.	Be	17. Father's Name (First, Middle,					18. Mothe	er's Nam	e (First, Middle	, Maiden Si	urname)		
yla	Men J Men narka netic	2	Willie McLear							ubman				
Z	d 2 sl th and traur	11 8	19a. Informant's Name/Relations Paula McLean			. Mailing Address							Code)	
ē,	s 1 and 2 should f Health and Men itam 27 Is marks othar traumetic		20a. Method of Disposition	(SISCEL)	20b. Place o	05 Moye f Disposition (Nam ry, crematory or o	er S	ot. I		Date		3] ition - City or To	wn. State)
E	Pages nent o nt: If	П	1 □ urial 2 □ Cremation 1 □ Onation 5 □ Other (S			ry, crematory or o ed Heart			4 - 19	-05		lk,MD		
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 any injury or othar tr. once.		21. Signature of Funeral Service	Licensee		22. Name an	d Addres	s of Facilit	www.	ley Cl	navis	Jr. H	H	
			23a. Part1. Enter the disease or	complications that cause	ed the death. Do	2007	<u> ast</u>	<u>ern</u>	AVE	. Bali	to. M	ID 2123	3 1 Approxin	nate
8	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition		.c Arrhyt	hmia							Interval E Onset an	
	/Medical		resulting in death)	a.	s a consequence									
п	Examiner		Sequentially list conditions.		dial Fib									
.7	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	of):								-
٧.	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence	of):								
8760,	icate be executed physician and s the burial-transit	dlcal		d										
9	rtifical ng phy as th	led	IS SCHALE											
Вох	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 Fetal death at time of death	3 □Ectopic pre					230	d. Date of delive Month	ry Day	Year
P.0.	it the d by the tached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown	at time or double	3 Li Ottier (apr	sciiy)							
G.	ires thal signed b	by P	Part II. Other significant condition	ons contributing to death	but not resulting in	the underlying ca	ause give	n in Part I.		23e. Did t	obacco use	contribute to th	e cause o	of death?
ord	w require been sig should b									1 🗆 '	res 2 📶	Vo 3 ☐ Prob	ably 4 [Unknown
Vital Records,	e taw r has be je 2 sh	Completed								24a. Was		24b. Were autop	sy finding	s available
E H	: The cate ?	Con								perfo	rmed? 2□ No	death2	2□ No	. 04800 0.
Vita	ysicien: The is certificate hadirector, page	Be c	25. Was case referred to medical examiner?	Hospital:			Otho			(Check only o			at	scene
of	H 두 F	. To	1 ☐Yes 2 ☐ No 27. Manner of Death	28a. Date of Inj (Month, D			_	4 🗆 140		me 5 Residente Particular Residente Particular Residente		Other (Specify	, ac	SCEITE
ion	nding F ath. r: After e funer	atlor	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		ay Year) li	njury M	3c. Injury Work 1 Y	? 'es 2 □!						
Division of	or Attanding after death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28e. Place of In	njury - At home, fa etc. (Specify)	rm, street, factory,	office			28f. Location (S City or Tox		lumber or Rural	Route Nu	ımber,
	urs afte	Cer												
	To the Hospitel or Attank within 24 hours after death To the Funarel Director: completely filled in by the	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the bes Examiner: On the basis and manner s	of examination and	, death occurred a d/or investigation,	t the time in my opi	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) an date and pla	d manner as sta ace, and due to	ited. the cause	e(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	1		29c.	License	number			29d. Date s	igned (Month, L	ay, Year)	1
			Mayore (Brelkrill	nn		0.0	C.M.E	I.		April	10, 20	05	
	1 d- per	7	30. Name and address of person											
	-		31. Date filed (Month, Day, Year)	D. KOREL	trar's Signature	1 Penn S	treet	t, Ba	ltin	ore, Ma	rylan	d 21201		
*	Sta Registr				1	•	_	.0						
DIII		01		APR 2 0 2005	Marie 14	& A	1234							

ORIGINAL

			1 = For Stata Registrar	State of	Marylan	-	artmen rtificat				lental Hyg	giene Reg. No	201	15	13381
П	Physic	ian	Decedent's Name (First, Middle, L.	,							2. Date of Dea	ıth Da	ıv '	Year	3. Time of Death
	/Medi	cal	Odessa Montgom								April	4	یک	005	1130 AM
4	Examir	ner	4a. Facility Name (If not institution, gi Union Memorial	ve street and numb	er)				Location	of Death		40	. County o	f Death	
	Funeral		5. Social Security Number 6.	Sex 7.	Age (In yrs. I	ast birthday)	If Under	timo 1 Year	ore If Under	24 Hrs.	8. Date of Birth	1		9. Birthol	ace (State or Foreign
U	Director		213-54-2010	1 □ M 2 🛣 F	(60 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 6 – 12 – 4	, Year)		Count SC	ry)
	and *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							140	
	Maryl f sho	Į.	MD		1									10	od. Inside City Limits 1X Yes 2 □ No
	r 28a	Director	10e. Street and Number		ва.	ltimo	re 10f. Zip	Code			1	IOa. Cit	tizen of Wh	at Count	
	th wit	al D	2808 Clifton P	ark Teri	race		21	218				USZ			,
	r dea	Funeral	11. Marital Status	12. Was Decede Armed Force	as Constant to	S. 13. V			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race -	America White, e	
36	ours after death with the Marylan rat', or Items 23a or 28a-1 show Exterither inset be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	∑ N0	ł ·	I □ Yes 2		Specify:		1110477, 01017		Specify:		
9	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show salical Exemitrant was benefited at		15. Decedent's E	Year or Date	s:	16a. Deced	lent's Usua	I Occupa	tion			16b K	ind of Busi		
215	within 73 ene. than "na	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4)	or 5±)	(Give	kind of wor OO NOT us	k done d	urina mos	t of worki	ng	IOD, K	ind of busi	nessma	ustry
2	filed within Hygiene. other than	Con	11th	College (114)	31 34)	Nurs	ing					Pri	ivate	<u> </u>	
and	be filed ntal Hygie nd other avant, II	Be	17. Father's Name (First, Middle, Las.	•							(First, Middle, I	Maiden	Sumame)		
Maryland 21215-0036	2 should be and Mental Is marked (aumatic av	T ₀	Dave Montgomer 19a. Informant's Name/Relationship	*		405 44 33					ooper				
Ma	ges 1 and 2 should be filed within 7 to Health and Mental Hygiene. If item 27 Is marked other than "n or other traumatic avent, Ire Mexil				torl						I Route Number			ate, Zip (Code)
ē,	s 1 and f Health itam 27 other tr		Gloria Montgom 20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Nam	ne of			am MD.		0 / U 6 ocation - Ci	ty or Tow	n, State
Baltimore,	pernit. Pages t a Department of Hea Important: If itam any njury or othe		1 ☐ Burial 2 【Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		10	ometery, crem ZView				1_18			ndalk		
<u>=</u>	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee							ley Ch	avi	s Jr	F	н Н
<u> </u>	ទីភូឌី ឌី <u>ឱ</u>		Nanell L.	Hunt	21	20	007 I	East	ern	Ave	. Balt	ο.			
Ĭ.			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause on each	sed the death. I line.	. Do not ente	or the mode	of dying	, such as	cardiac o	r respiratory arre	est,			Approximate nterval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Myoc	grala	1 int	avefi	001							Onset and Death
6	Examiner			Due to (or	as a consequ	ence of):	•								-010-
4		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	Sho	once of).						_		T	day
	od ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
Ö,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or :	as a conseque	ence of):									
8760,	cate be executed physician and the burial-transit	Physician/Medical		d											
9	death certifica e attending ph d for use as ti	/Mec	IF FEMALE:	23c. If yes, outcon	an of program										
Вох	atten f for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal	death 3 🗌	Ectopic pre Other (spe					2	23d. Date o Month		ay Year
o.	0 0 0	hysl	1 Yes 2 No 9 Unknown	9□ Unknown		atti 5	Other (spe	-Ciry)							
S,	The law requires that the tte has been signed by thoage 2 should be detached	by P	Part II. Other significant conditions	contributing to death	but not resul	lting in the un	derlying ca	use giver	in Part I.		23e. Did tob	acco u	se contribu	ite to the	cause of death?
ğ	w require been sig should b										1 ☐ Ye	s 2[]No 3[Probab	oly 4 Junknown
Record	e law r has be ge 2 sh	Completed									24a. Was an		24b. Wei	e autops	y findings available
_		Соп									perform		dea	th?	Distion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						of Death	(Check only one	9)			
	hys this	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 Linpa 28a. Date of Ir		R/Outpatient 28b. Time of			4 1401		e 5 Resider			Specify)	
Division of	th. : Afte	ıtlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	ay Year)	Injury	M	c. Injury a Work?	?' es 2 🖺 N		8d. Describe hor	winjury	/ occurred		
N N	if or Attending Patter death. Director: After the fin by the funera	ertification;	3 Suicide 6 Could not b	28e. Place of f	njury - At hon	ne, farm, stre	et, factory,	office		2	8f. Location (Str.	eet and	d Number o	or Rural F	Route Number,
	spital or A ours after naral Direc filled in by	Cert	4 E Homeide	building,	etc. (Specify)						City or Town,	State)			
	To the Hospital or A within 24 hours after To the Funaral Director completely filled in by	edical	Check only Z Medical Exal	nysician: To the bes	of examination	ledge, death	occurred a	t the time	, date and	place, a	nd due to the ca	use(s)	and manne	or as state	ed.
	To the Hos within 24 ho To the Fun completely	Med	one) 29b. Signature and title of certifier	and manner	stated.			License							
	⊢ ≥ ⊢ 3		De west al and	m Mu)					àU1-			signed (A	Jonan, Da	y, rear)
			30. Name and address of person who	completed cause of	death (Item 3	23a) (Tvna P	rint)	1 01 -	00	1701	F7 1	IN	1 /	ن ر	(00)
_			^	SMan	201	EU	112	1/4	Post	Way	Kultin	NOVE	MO	2	1218
	Sta		21 Date filed (Month Day Year)	32 B	trar's Signatu										U
	Registra	ar	APR 2 0 2	CUU	بر معن	J. 1	Sept.								

	ŕ	For State Registrar			f Marylan		artment rtificate			d Mental F	Reg. I	Em 0 0	5	33	85
Physicia	n	1. Decedent's Name Lucille		ast) :hieson						2. Date of April		Day 2005	'oar	Time of 10	Death Рм
/Medica		4a. Facility Name (If I			mber)		4b. City, To	own, or Loc	cation of De			4c. County of		10	
Laumin		Friends	Nursin	g Home			Sand	dv Sp	rings			Montg	omery		
Funeral Director		5. Social Security Nui 202-20-859		Sex 1□M 2X□F	7. Age (In yrs	last birthday) Yrs.	If Under 1	Year If	Under 24 H lours M		Birth Day, Yes 6, I	926 P	Birthplace Country) ennsy1	(State of	r Foreign La
and w	}	Usual Residence of E	Decedent 10b. County		10c. Cit	y, Town or Lo	cation						10d. Ir	nside Cit	ty Limits
Maryi -1 sho fied a	ğ			Georges		ırel								☐ Yes	
or 28s	ojrec	10e. Street and Numi					10f. Zip C	ode			10g. (Citizen of Wh	at Country?		
e 23e	ra	15403 Ma1	aya Pla				2070					nited			
ifter de	Funeral Director	11. Marital Status1 ☐ Never Married	d 2∐ Married	Armed Fo 1 ☐ Yes			f Yes, specify	y Cuban, M	inic Origin? Nexican, Pu	(Specify Yes or erto Rican, etc.)	No-		American In White, etc.	dian,	
reit, o	ē.	3 🗷 Widowed 4	Divorced	If Yes, Giv Year or D			1 □ Yes 25	No S	pecify:			Specify:	Whit	е	
in 72 h	Completed	(Specify		rade completed)		(Give	dent's Usual (kind of work of DO NOT use	done durin	n ng most of w	vorking	16b.	Kind of Busin	ness/Industry	/	
d with giene.	mo.	Elementary/Second	dary (0-12)	College (1	-4or 5+)			,	able	Manager	Ma	anufact	uring		
be file tal Hy d oth event	Be	17. Father's Name (F Edward S		st)						lame (First, Mid		,			
hould d Men marke matic	0	19a. Informant's Nan		(Type Print)		10h Mailie	a Addrace (6			e Willia Rural Route Nu			ata Zia Cade		
nd 2 saith an 27 is in treui		Mrs. Georg			ster					Laurel,				9)	
es 1 a of Hei of Heim fitem r othe		20a. Method of Dispo	sition	☐Removal from S	20b. P	lace of Dispo emetery, crer	natory or othe	er place)	Apr	Date il 23,	20c.	Location - Ci	ty or Town, S	State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other than "naturel", or iteme 23e or 28e-f show any injury or other treumatic event, Ite Madical Examinar must be notified at once.		'4 □ Donation 5	Other (Spec	eify)	Hil	llcrest			ns 2	005	Anr	napolis	, Mar	ylan	ıd
Departing any ir		21. Signature of Fund	era Service Lici	ensee	\wedge	K j	rkley-	Address of Rudd	ick F	uneral H	lome,	P.A.	n 010		
STREET.		23a. Part1. En er the	di ease, or con	mplications that cay	aused the death							irnie M	App	O L roximate val Betw	
Physician		Immediate Cause (F disease or condition		5 e	>0116	o d	em	on	tia					et and D	
/Medical Examiner		resulting in death)	1	Due to (or as a consequ	uence of):							,	/ C 	
	Jer	Sequentially list conditions, leading to imm	ditions, nediate	b. Due to (or as a consequ	uence of):							-		-
nd	Examiner	that initiated events	jury	c											
cate be executed only sician and the burial-transit	EX EX	resulting in death) La	ıst	Due to (or as a consequ	uence of):									
is is	edical			d											
eath certific attending pl	M/UE	IF FEMALE: 23b. Was decedent p		23c. If yes, out	come of pregna		Ectopic pregi	nancy				23d. Date o			
the att	Physician/M	in the past 12 m 1 Tes 2 Tes 9 Tes			ant at time of de		Other (speci				-	Month	Day	Y	ear
res that the de signed by the a be detached to		Part II. Other signific	ant conditions	contributing to de	eath but not resu	ulting in the u	nderlying caus	se given in	Part I.	23e. Di	d tobacco	use contribu	ite to the cau	use of de	ath?
w requires	ed by									1	☐ Yes	2) No 3[Probably	4 □Ur	nknown
law re nas be	Completed										topsy	prio	re autopsy fir r to completi		
ncien: The law certificate has rector, page 2 s	-	05.111.								pe 1 ☐ Ye	rformed?	dea 1	th? Yes 2X	No	
yelclen: s certific director,	o ne	25. Was case referre examiner? 1 ☐ Yes 2 ☑ N		Hospital:	npatient 2 🗆	ER/Outpatien	t 3 DOA	0.1	616	eath <i>(Check on)</i> Home 5 R		6 Other	(Specify)		- 27
ng Phye	- iu	27. Manner of Death	5 Pending	28a. Date o		28b. Time of Injury		Injury at Work?	, 4			jury occurred	Ореспу		
ttendii death. tor; A the fu	Cati	2 Accident	investigation	bo -	-61-1 441		М	1 🗆 Yes	2 🗌 No	001.1	(0)				
after after I Direct	Certification;	4 Homicide	determine	d 286. Place buildir	of Injury - At ho ng, etc. (Specify	me, rarm, str	eet, ractory, o	office			Town, Sta	and Number (ite)	or Hurai Hou	te Numb	er,
	edical C	29a. Certifier 1 (Check only 2	Certifying P	hysicien: To the miner: On the ba	isis of examinat	wledge, death tion and/or inv	occurred at the estigation, in	the time, d	late and pla- in, death oc	ice, and due to the curred at the time	ne cause(e, date a	(s) and manno nd place, and	er as stated. due to the c	ause(s)	
withir To th	Me	29b. Signature and tit	tle of certifier	1				icense nui			A	ate signed (A	-		
11	-	Faul	www	0			D	792	137		HP	ril (8,2	00	5
9		30. Name and address Paul Ar	mrtr	o completed cause of ing i m 32. Re 2 0 2005	e of death (Item	23a) (Type,	Print)	814	. Pr.	#102 L	uve	elm	p 20	70	7
State Registra	- 1	31. Date filed (Month,	Day, Year)	32. Re	egistra s Signat	ture &	Local								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death		giene 0 0 5 Reg. No.	13386
Physicia	an	1. Decedent's Name (First, Middle, Last,		.11	T		2. Date of Dea Month	Day Year	3. Time of Death
/Medic		Thomas Edw 4a. Facility Name (If not institution, give		ıllaney	Jr 4b. City. Town, or	Location of Death	April 1	16, 2005	3:33 am™
Examin	e:	5650 Denfield Pla			Adams			Freder	
Funeral Director		013-02-1900		rs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 4,		place (State or Foreign ntry) ifornia
* II		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
is marked other than "natural", or itams 23a or 28a-f show aumatic event, the Madical Examiner must be nutified at	tor	Maryland Frederic	ck	Adam	stown				1 ☐ Yes 2 🙀 No
tou a	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Cou	ntry?
dist	ral	5650 Denfield Pla				21710		U.S.A.	
	by Funeral	11. Marital Status 1 □ Never Married 2(∑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, White	etc.
	ted t	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occupa	ition		16b. Kind of Business/Ir	hite
	Completed	(Specify only highest grad	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of worki)			,
Ŗ.	Con	12		Fur	niture Ir			President/	Design
	Be	17. Father's Name (First, Middle, Last) Thomas Edward	Mullaney	Sr		18. Mother's Name	e (First, Middle, i	_ ′	1
	ဥ	19a. Informant's Name/Relationship (Ty	,		ng Address (Street a		al Route Number	Gammor r, City or Town, State, Zij	
		Monique M. Gaunt	Mullaney/Wif					vn, Maryland	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lam aval from Chain	. Place of Dispo	sition (Name of natory or other place	9)	Date	20c. Location - City or T	own, State
		'4 □Donation 5 □Other (Specify)	S	t. Josep	oh's Ceme	tery Apr	22,2005	Pittsfield	, Mass
once.		21. Signation of Funeral Service Lichns 23a. Part 1. Enter the disease, or compleshock, or hear failure. List only or	MOO	706 10	. Name and Addres Keeney & 6 East Cl er the mode of dying	Basford Jurch St.	P.A. Fur Freder or respiratory arr	neral Home ick, Maryla	nd 21701 Approximate Interval Between
an cal		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		KE				Onset and Death 2 YEARS
ner		Sequentially list conditions							
٦	lner	Sequentially list conditions, if any, leading to immediate cause. Enter the chiping Cause (Disease or injury	Due to (or as a cons	equence of):					
	al Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
	edlcal								
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ery Day Y <i>e</i> ar
	þ	Part II. Other significant conditions cor	ntributing to death but not r	esulting in the u	nderlying cause give	n in Part I.	23e. Did tot	bacco use contribute to t	he cause of death?
	Completed						24a. Was a autops perforr	sy prior to co med2 death?	ppsy findings available impletion of cause of
	Bec	25. Was case referred to medical examiner?				26. Place of Death			
	2	1 ☐ Yes 25 No	lospital: 1 Inpatient 2			4 Nursing nor		ence 6 Other (Specif	(y)
	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	es 2□No		ow injury occurred	
		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, streetfy)	et, factory, office		28f. Location (St City or Towr	reet and Number or Rura n, State)	al Route Number,
	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as s ate and place, and due to	tated. o the cause(s)
	7	29b. Signature and title of certifier	Alm. D.	41.0	29c. License			9d. Date signed (Month,	
	-	1 Waser	1 come	-1/3		1761		April 16, 2	005
		30. Name and address of person who co				E	1	M 1 1 0	4704
Sta	te.	Brian M. O'Conno 31. Date filed (Month, Day, Year)	r, M.D., 501	west Si	eventh St	reet, fre	derick,	Maryland 2	1/01
عاد egistr،		APR 2 0 2005	Blown &	1	7 7				

PD			1 - For State Amend Item Registrar	State of Ma 1&UNpend Ite	uryland / Depa m 23a&2 / _e]	artment of F per me G8 dificate of	lealth and N 43 5-11-0 Death	lental Hyg 5 tas	eg. Nb. 005	13387
	Dhysia	ion	1. Decedent's Name (First, Middle					2. Date of Dea Month	th	3. Time of Death
	Physic /Medi		Richard L. Ma					April	Day Year 12, 2005	1020 A M
	Exami	ner	4a. Facility Name (If not institution Peninsula Regio		Contor	46. City, Town, or Salisbur	Location of Death	-	4c. County of Death Wicomico	
9	Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year	y If Under 24 Hrs.	8 Date of Birth		place (State or Foreign
2	Director	Н	216-19-1185	1 XM 2□F 34		Months Days	Hours Min.	8. Date of Birth (Month, Day) 10-20-7	Year) Cou	place (State or Foreign intry) Md.
5	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d Inside City () - in-
	Maryl f sho	ō		ssex	Delmar	04(10))				10d. Inside City Limits X□Yes 2□No
	h the	Director	10e. Street and Number		Dermar	10f. Zip Code		1	0g. Citizen of What Cou	intry?
	th wit	a D	2 W. Grove St.			19940			USA	
	er dez	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Vas Decedent of H f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
336	irs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🔀 Divorced	ied 1 ☐ Yes 2 █ X N If Yes, Give Year or Dates:		I □ Yes 🏖 No	Specify:		Specify: Whi	
21215-0036	72 hou		15. Decedent	's Education	16a. Deced	ent's Usual Occup	ation		16b. Kind of Business/Ir	
21	ithin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+	life. L	kind of work done o OO NOT use retired	iuring most of work)	ing		
12	iled w Hygier Iher ti		12 17. Father's Name (First, Middle.	(act)	Cor	nstructio		- 150	Tile	
Maryland	d be f	To Be	Richard L. Mat	- 4			18. Mother's Name	e (FIRST, MIGGIE, F arrison l		
ary	shoul and M s marl umati	F	19a. Informant's Name/Relations		19b. Mailin	g Address (Street a			City or Town, State, Zip	o Code)
Σ	and 2 salth s n 27 ls	1	Ruth F. Matthey	ws, Mother		Grove St		De. 19		
Baltimore,	of He		20a. Method of Disposition 1 Derial 2 Cremation	3 ☐Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other plac			20c. Location - City or To	own, State
菲	t. Pag rtment rtant: ijury o		`4 ☐ Donation 5 ☐ Other (Si	pecify)	Crematory			5-05	Delmar, D	e.
Bal	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.		21. Signature of Funeral Service	Licensee	of St	Name and Addressort Fune	ral Home			
	A.		23a. Part1. Enter the disease, or shock, or hear failure. List	complications that caused t	he death. Do not ente	E. Grover the mode of dying	e St. Del g, such as cardiac	mar, De	19940	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Diabetic	Ketoacido					Interval Between Onset and Death
	Examiner			Due to (or as a	consequence of):					
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	cons quence of					
	ecuter and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.						
68760,	ificate be executed g physician and as the burial-transit	al E	The second secon	Due to (or as a	consequence of):					
687	ificate g physis the	edical		d						
Вох	eath certif attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		C-1			23d. Date of delive	ery
P.O. B	at the death by the atte	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at ti		Ectopic pregnancy Other (specify)			Month	Day Year
S, E	es tha igned l	by P	Part II. Other significant condition	ns contributing to death but	not resulting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
ord	w requir been si should	O		-				1 □ Ye	s 2 No 3 Prob	ably 4 Unknown
Division of Vital Records,	e la has	Complete		·				24a. Was ar autopsy perform 1 X Yes 2	prior to conded?	psy findings available mpletion of cause of 2 No
/Ita	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one))	
of	Physicia this cert ral direct	.T	1X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury		3□ DOA Cthe	C 4 ☐ Nursing Ho		nce 6 Other (Specify	/)
O	ding Ph th. After th funeral	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Day	Year) 28b. Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe ho	w injury occurred	
Visi	Attendii r death. actor; A by the fu	ifica	3 Suicide 6 Could n	ot be 28e. Place of Injury	y - At home, farm, stre			28f. Location (Str	eet and Number or Rura	I Route Number,
	spital or Atten ours after deat naral Diractor; filled in by the	Certification;	4 Notticide	building, etc.	(Specify)			City or Town,	State)	
	Hos Fur ely	edical	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best of examiner: On the basis of examiner state	xamination and/or invi	occurred at the time estigation, in my op	e, date and place, a inion, death occurr	and due to the ca ed at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month, i	Day, Year)
			I hay he	, m.D		OC	ME	Aı	oril 14, 20	05
			30. Name and address of person v	2h. D		111 P	enn Stree		imore, Mary	
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)	2 0 2005	Signature	Sicil .				

			1 - For State Registrar	State	e of Maryla		artment of H		Mental Hyg	giene 005	13388
	Physici		1. Decedent's Name (First, Midd Betty	le, Last)	ou	McN	ally		2. Date of Dea Month April	Day Year 15 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	n, give street and	number)		4b. City, Town, or	Location of Dea		4c. County of Dea	3:25 pm ^M
	Examin		Genesis Elder	care - S	Spa Cree	k	Anna	polis		Anne A	rundel
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			thplace (State or Foreign ountry)
	Director		213-80-2475	1 □ M 2 🔀	F 70	6 Yrs.	Monary Days	TIOUIS IVIII	Dec. 24		ryland
	and	}	Usuel Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Manyi f sho	ö	MD Design								1 ☐ Yes 2 🔏 No
	the 28e-	Director	MD Prince 10e. Street and Number	e Georg	es	River	10f. Zip Code		1	log. Citizen of What C	ountry?
	h with		4807 Tuckerman	Street				20737		USA	,
	deat	Funeral	11. Marital Status		Decedent Ever in d Forces?	1 U.S. 13.	Was Decedent of Hi	spanic Origin? (Specify Yes or No- into Rican, etc.)	14. Race - Am	
36	or Ite		1 Never Married 2 Mar	ried 1 TY	es 2 X No	1	- 77	Specify:	nto rican, etc.)	Black, Whi	White
Ö	d within 72 hours after death with the Maryland jiene. rithen "naturel", or ttems 23a or 26e-f show the Madical Examiner must be notified at	ed by	3 Widowed 4 Divorced	Year	or Dates:						
15	in 72 n "nai	Completed	(Specify only highe	-		(Giva	dent's Usual Occupa kind of work done of DO NDT use retired	furing most of w	orking	16b. Kind of Business	/Industry
212	l within liene.	mo	Elementary/Secondary (0-12)	Colleg	je (1-4or 5+)	Cler		,		Food Servi	ice
b	e filed al Hygie other vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle, I	Maiden Surname)	
Vlai	should be and Mental marked o	To	Robert J. McNa	11y				Lill	ian Aeron	smith	
Maryland 21215-0036	CJ CG CD		19a. Informant's Name/Relations	ship (Type, Print)						; City or Town, State,	
e)	fealth fealth im 27 her tr		Daisy L. Purso	chwitz (4807 b. Place of Dispo		n Stree	-	lale, MD 20	
Baltimore,	iges or of h		1 Burial 2XX remation		om State	cemetery, crei	natory or other place	*		20c. Location - City or	
ij	it. Partmer		'4 □Donation 5 □ Other (\$21. Signature of Funeral Service	_	Me	etro Cre	matory Name and Addres		.9-2005 B	Baltimore,	MD
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		17-0	.()		22	Hardesty	Funera.	1 Home,P.	Α.	
			23a. Part1. Enter the disease, o	r complications th	at caused the de	eath. Do not ent	12 Ridge er the mode of dying	ly Aveni g, such as cardia	ue, Annap ac or respiratory arre	olis, MD 2	Approximate
	Physician		shock, or heart failure. List	only one cause	on each line.	0					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue	to (or as a cons		more				/w
ŀ	Examiner		Sequentially list conditions	b							
	Sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classe or injury	Due	to (or as a cons	sequence of):					
_	and i-tran	хаш	that initiated events resulting in death) Last	C	to (or as a cons	equance of):					
8760,	death certificate be executed e attending physician and of or use as the burial-transit	dical E			10 (01 00 0 0010	, oqua, 100 01/.					
687	tificate ig phys as the	edic		d					-		
Вох	eath certifi attending for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pre		3			23d. Date of de	livery
	death e atte	icia	in the past 12 months?	4□Pr	ve birth 2 □ F regnant at time o]Ectopic pregnancy] Other (specify)			Month	Day Year
P.O.	that the ed by th detache	hys	9 □ Unknown		nknown						
Ś	Se UL e		Part II. Other significant conditi	ons contributing t	o death but not i	resulting in the u	nderlying cause give	n in Part I.		pacco use contribute to	
ord	nedui een s	ted							1 🗆 Ye	as 2DNo 3□Pi	robably 4 Unknown
Vital Record	× - 0	Completed							24a. Was a autops	y prior to	utopsy findings available completion of cause of
alF	t: The icate he								1 Yes 2	ned? death? 2□Vo 1□Yes	2 □ No
	Physicien: The la r this certificate has ral director, page 2	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ ₩o	Hospital		ПЕРИ	Othe		eath Check onl on		
of	rding Phy th. : After this funeral d	. To	27. Manner of Death	28a. D	ate of Injury	ER/Outpatien	28c. Injury	at		ence 6 Other (Spe	cify)
ion	Attending ir death. ector: After by the fune	atloi	1 SHatural 5 ☐ Pendir 2 ☐ Accident investi	9	Month, Day Year,) Injury	Work	? ′es 2 □ No			
Division	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Pl	ace of Injury - A	t home, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ri	ural Route Number.
ā	rs after rel Dire	Cer							Only of Town	, otale,	
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director:	edicai	29a. Certifier Check only one) Check only	Exeminer: On th	the best of my keep basis of exam nanner stated.	knowledge, death ination and/or inv	occurred at the tim restigation, in my op	e, date and plac inion, death occ	e, and due to the ca curred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of certifie				29c. License			9d. Date signed (Mont	
P	1	1	1 / 4 /	Mu	M		U_	2703	6	4/16/2	COJ
	11		30. Name and address of person	50001	ause of death (I	tem 23a) (Type,	Print)	ch Di	ve Che	4/16/2 th, Mi)	21619
Ì	Sta Registra	te ar	31. Date filed (Month, Day, Year	PR 20%	Strar's		J. James				

M	ILO		1- For Unpend Item	State of Maryla 23a&27 per m	and / Depa e G843	artment of E	lealth and N asd Death			12200
	Physic		Decedent's Name (First, Middle, Last Michael	Charles		MacEwe		2. Date of Death April 16	Day Yeer	3. Time of Death 4:10p M
	/Medi Examii		4a. Facility Name (If not institution, give 5980 Rockhold Cree				r Location of Death		4c. County of Deat Anne Arur	h
0	Funeral Director		5. Social Security Number 6. Se 216-98-3347	VM OFF	rs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 9, 1		nplace (State or Foreign unity) Linois
	e Maryland Ba-f show	ctor	10a. State 10b. County MD Anne Ar		City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with th	Funeral Director	10e. Street and Number 5980 Rockhold Cr	eek Road		10f. Zip Code	0751		Citizen of What Co USA	untry?
920	urs after de al', or Itams Exercicer n	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 198		Was Decedent of Hi f Yes, specify Cuba I □ Yes XX No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I then the markad other then "natural", or Itams 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Deced (Give life. L	DO NOT use retired	during most of work	ing 16b	Kind of Business/I	ndustry
	ould ba filed with Mental Hygiene. arkad other ther atic event, Ire M	To Be Co	12 17. Father's Name (First, Middle, Last) John C. MacEwen		_ Wait	er		e (First, Middle, Maid	Restauran en Sumame)	t
, Maryland	os 1 and 2 should in the stand Men item 27 Is marka to that traumatic	-	19a. Informant's Name/Relationship (7) Janet E. MacEwen				and Number or Run	al Route Number, Cit ad, Deale		
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Metro Cr	ematory or other place	θ) 4-21		Location - City or T ${f ltimore}$,	
Bal	permit. Departr Imports any inji	1	21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Rations that caused the de	lv Avenue	Home, P.A., Annapol	is, MD 21	401 Approximate		
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Atherosclere Due to (or as a cons				Interval Between Onset and Death		
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
,0928	cate be exacuted physician and the burial-transit	dical Examine	that initiated events resulting in death) Last	Due to (or as a const	equence of):					
.O. Box 6	The law requires that the death certificate te has been signed by the attending physoage 2 should be detachad for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ords, P	w requires that been signed k should be deta	ρλ	Part II. Other significant conditions con	stributing to death but not re	esulting in the un	derlying cause give	n in Part I.		o use contribute to l 2 \	
Vital Records		Completed						24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
Division of Vit	Attending Physicien: or death. actor: After this certific by the funeral director,	ertification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 i 28a Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at 2	(Check only one) ne 5 Residence 28d. Describe how inj		y) At Scene
DİVİ		O	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			28f. Location (Street a City or Town, Sta	te)	
	To the Hospital or within 24 hours after To tha Funerel Dir completely filled in	Medical	(Check only one) 2 Medical Examination (Check only one) 2 Medical Examination (Check only one) 29b. Signature and title of certifier	sician: To the best of my kiner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my opi	inion, death occurre	ed at the time, date a	s) and manner as s nd place, and due to ate signed (Month,	o the cause(s)
)			30. Name and address of person who co	mpleted cause of death (Ite	√ em 23a) (Type, F		2- 6:		ril 17, 2	
	Sta Registr	2.	TAMBLITY 31. Date filed (Month, Day, Year) APR 2 0	32. Registrade Sign			Penn Stre	et Baltin	nore, Mary	yland 21201
				2407	and So	South				

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Box
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		Please	Type or Prin			<mark>delible Ink.</mark> artment of H		•	_	.	
		State Registrar			Cer	rtificate of L	Death		Reg. No. 0 0 5	13390	
Physici		1. Decedent's Name (First, Middle, La	ast)					2. Date of De	eath Day Ye	3. Time of Death	
/Medic		ELTRA ESTEI	LLA NELSON	N				04	18 200		
Examir	ner	4a. Facility Name (If not institution, give		1			Location of Death	•	4c. County of D	eath	
		Sinai Hospil				Baltim	ore City		N/A		
Funeral Director		,	Sex J 7. Aga 1 □ M 2 🛣 F	e (In yrs. last b 66	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Min.	8. Date of Bir (Month, Da	ay, Year)	Birthplace (State or Foreign Country)	
		219-32-9519 Usual Residence of Decedent						AUG 17	7 1938	MARYLAND	
how	-	10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits	
e Ma	cto	MARYLAND BAI	LTIMORE		OW	INGS MILI	LS			1 ☐ Yes 2 🛣 No	
라 라 or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?	
ath w	-a	5 AMBER LADY	COURT			2111	L7		U.S.A.		
er de Itams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	cify Yes or No Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4XX Divorced	1 ☐ Yes 2 🔯 the state of the	M/o	1	I□Yes 2⊠No	Specify:		Specify:	BLACK	
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d with	Completed	12th grade	2yrs		ENIO	R ADMINST	TRATOR		MD STA	TE/MVA	
al Hy Jothe	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	, Maiden Sumame)		
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In a Mental Hygiene. In a Mental Examiner matter and the natified and matter event.	T _O	GEORGE CHASE MABEL VAUGHN									
2 sh and Is m raum		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailin	g Address (Street a	nd Number or Rura	I Route Numbe	er, City or Town, State	e, Zip Code)	
ges 1 and 2 should be filled within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Health and Mental Hygiene. or other traumatic event, the Modesa Examiner must be nufficed at		Lorren E. Nelson	/Daughter	Joh Diese					Mills, Mo		
permit. Pages 1 Department of H Important: If ita any injury or ot		20a. Method of Disposition 1XDBurial 2 ☐ Cremation 3 ☐		cemete	ery, crem	sition (Name of natory or other place	9)	ate	20c. Location - City	or Town, State	
it. Pertrant		'4 ☐ Donation 5 ☐ Other (Special 21. Signature 5 ☐ Upola Selvice Dice	(N)	KING		RIAL PARK		3-05	BALTIMORE	MARYLAND	
permit. Departn Imports any inju		21. Signature Strain Contraction	DIOPPLANT!			Name and Address LL IAM C F		MUNITY	FUNERAL HO	OME P.A.	
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Dhusistan		Immediate Cause (Final	one cause on each in	10.						Interval Between Onset and Death	
Physician / /Medical		disease or condition resulting in death)	a. Sept	a consequence	ock	. due to	Cholec	ystitis		3days	
Examiner					3 017.						
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ecute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c							1. 51	
be executed sician and burial-transit	al Ex	resulting in death) cast	Due to (or as a	a consequence	e of):						
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The law requires that the death certificate tte has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medic	IF FEMALE:	23c. If yes, outcome	of pregnancy							
atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year	
at the de by the a	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown	timo or doda	30	Other (specify)					
s that	by Pi	Part II. Dther significant conditions of	contributing to death bu	at not resulting	in the un	derlying cause giver	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
w requires been sign should be		Coronary As	stery Dise	ase				1 🗆 Y	/es 25€No 3□	Probably 4 Unknown	
awre is bee 2 sho	plet	V	Q					24a. Was		autopsy findings available	
The lavate has	Completed							autop	rmed? prior t death	o completion of cause of es 2 No	
sician: The la certificate has irector, page 2	Bec	25. Was case referred to medical examiner?					26. Place of Death	1		03 92110	
Physician: this certificanal director,	P.	1 Tes 2 No	Hospital: 1 Inpatier	nt 2 ER/O	utpatient	3 DOA Other	. 4 Nursing Hon	ne 5 Resid	dence 6 □Other (Sp	pecify)	
ding P h. After t funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		Time of Injury	28c. Injury	at 2		now injury occurred		
tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	Α				es 2 No				
or A after Direc in by	ertification:	4 Homicide determined		iry - At home, fa (Specify)	arm, stre	et, factory, office	2	8f. Location (S City or Tow	Street and Number or . vn, State)	Rural Route Number,	
ppital ours cours leral filled	O	29a. Certifier 1 Certifying Ph	veicien: To the best o	f my knowloda	o doath	nonurrad at the time	n data and alarm	- 4 - 4 - 4 - 4 - 4			
24 hos Fun	edical	(Check only 2 Medicel Exen	ysicien: To the best o niner: On the basis of and manner stat	examination ar	nd/or inve	estigation, in my opi	nion, death occurre	nd due to the d d at the time, d	cause(s) and manner date and place, and d	as stated. ue to the cause(s)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	station state			29c. License	number	- 2	29d. Date signed (Mo	nth, Day, Year)	
/ /		Shadini	B MD			RES	- 000	1.0	4		
h		30. Name and address of person who		eath (Item 23a)	(Type, P		000	<i>{-</i>	tone 18	1	
9		SHALINI BOYAPA				TAL OF BA	LTIMORE				
Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	Lan	als I					
Registra	ar	APR 2 0 201	05 Donner	1 15	Part						

			For State	State of M		artment of Hea			0000	
			Registrar 1. Decedent's Name (First, Middle, L	.ast)		timeate of De		Rag	g. No.	3 Time of Death
	Physic		Eleanor M	argaret	Owings			Month _	Day Year	15-6/ CM
	/Medi Exami		4a. Facility Name (If not institution, g	ive street and number,		4b. City, Town, or Loc	ation of Death	· · · · · · · · · · · · · · · · · · ·	4c. County of Deat	h
			Annapolis Nurs 5. Social Security Number 6.		b • ge (In yrs. last birthday)	Annapoli		. Date of Birth	Anne Ar	
	Funeral Director		216-12-6652	1 M 2 XF	91 Yrs.		ours Min.	Month, Day, 1 June 23	rear) Co	nplace (State or Foreign untry) ryland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f sho	ğ	MD Anne	Arundel	Annapo	olis				1√Xes 2 No
	r 28e	rec	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	
	th wit	aD	900 Van Buren S	treet		21403	3		USA	
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. do other than "naturet", or Items 23a or 28e-f show event. The Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 M If Yes, Give Year or Dates:	No	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2X No Sp	nic Origin? (Speci exican, Puerto Ri pecify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
5-0	72 ho	Completed	15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usual Occupation kind of work done during	a most of working	16	6b. Kind of Business/I	ndustry
2	- 100	nple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired)	g most of working			
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ano	d be f	o Be	Basil Allan Owi			18.	,	Pirst, Middle, M2 Darling		
Maryland	2 should be filed within and Mental Hygiene. is marked other than eumatic event, the M.	2	19a. Informant's Name/Relationship		19b. Mailii	ng Address (Street and N				in Code)
	5 등 2 후		Tilden O. Atwel	l (POA)		aney Avenue				,, , , , , , , , , , , , , , , , , , , ,
Jre,	of Hea		20a. Method of Disposition		20b. Place of Dispo		Dat		c. Location - City or 1	own, State
Ē	Pag nent ant: i		1 ABurial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	ify)	1	d Cemetery	4-21-2	2005	Salesville	, MD
Baltimore,	permit. Pag Department Importent: i eny injury c		21. Signature of Funeral Service Lice	en en en en en en en en en en en en en e	22	Name and Address of Hardesty F	Facility uneral H	Iome, P.A		
	0 11 7 9 Q		22a Boutt Sator the disease or se	0		12 Ridgely	Avenue,	_Annapo	lis, MD 21	1401
	211		23a. Part1. Enter the disease, or conshock, or heart failure. List onlinediate Cause (Final	y one cause on each I	ine.	er the mode of dying, su	ch as cardiac or r	espiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. ASP	a consequence of:	Preveno	110			one day
18760,	cate be executed physician and the burlal-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as d.	a consequence of):					one worth
.O. Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	rery Day Year
S, D	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause given in l	Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ord	w require been sig should b							1 🗆 Yes	2 No 3 □ Pro	bably 4 Unknown
Vital Record	The law ate has b page 2 st	e Completed							prior to co	opsy findings available ompletion of cause of 2 No
	Physicien: this certific ral director,	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatio	ent 2 ER/Outpatien	Other	Place of Death (C		e 6 Other (Speci	4.1
J Of		Ë	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time of	28c. Injury at Work?		d. Describe how		(y)
ior	Attending Ir death. sctor: After by the funer	atio	1 Vatural 5 Pending 2 Accident investigate	on	y reary injuly	M 1 Yes	2 🗆 No			
Division		Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	200. Flace of III	ury - At home, farm, str c. (Specify)	eet, factory, office	28f.	Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier Certifying P	hysician: To the best miner: On the basis o and manner st	t examination and/or inv	occurred at the time, da restigation, in my opinion	ite and place, and , death occurred	I due to the caus at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License num	nber	29d.	Date signed (Month,	Day, Year)
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	1/1/		30. Name and address of person who 2/08 D, Time	,		Print)	/	(16	, , ,	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	act Wi) /	619		
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ı	Physic											
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De		4c. County of De			
	Funeral Director		5. Social Security Number 212 · 28 · 0810 Usual Residence of Decedent	4	(In yrs. last birthday) [2 Yrs.	If Under 1 Yea Months Day			1932 9. E	Sirthplace (State or Foreign Country)		
	Aaryland f show	o.	10a. State 10b. County MD NA		10c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	th the N or 28a-	Director	10e. Street and Number		DHLIMOR	10f. Zip Code			10g. Citizen of What			
	ns 23a	Funeral D	44 N. ATHOL ANA	ENUE 12. Was Decedent E	verin IIS 13	212.	- 1	/5	USA	•		
900	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show ta Mudical Examirat mast be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 May Yes 2 No of Yes, Give Year or Dates:	0	was becedent or If Yes, specify Cu 1 ☐ Yes 2 🌠 No		(Specify Yes or No- erto Rican, etc.)	0	nerican Indian, nite, etc. 3LACK		
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nore	Pages 1. nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	1 -	natory or other pl	,	Date	20c. Location - City			
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	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ar there	scleratic u	/	clistes		rest,	Approximate Interval Between Onset and Death		
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	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):							
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		Completed by	,					24a. Was a autops perform				
Z X	S 0 = 0	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) \(\text{H} \)	lospital:	2 FR/Outpatien	3 DOA Ct	hor	eath (Check only on	ence 6 □Other (Sp	AC(fu)		
Division of	Jing After fune	Certification: T	27. Manny of Death 1 atural 5 Pending investigation	28a. Date of Injury (Month, Day		28c. Inju			ow injury occurred	ос пу)		
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1 -	1		30. Name and ress of person who co Matthew H. Walke	mpleted c. se of dea	ith (Item 23a) (Type. I				_			
Y) \		21 5 . () . ()		- 01			Ltimore,	Md 2120	<u> </u>		
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Physician Director Death	13393
Medical Examiner Louis Patras, Sr. April 16, 2005	3. Time of Death
Funeral Director 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. Ford Harford Memorial Hospital Funeral Director 9. Birth (Month, Day, Year) 1	5:59 PM M
Funeral Director 5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) Anoths Days Hours Min. Social Security Number 1213-28-8879 Usuel Residence of Decedent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 12 Months Days Hours Min. Social Security Number 74 Yrs. Months Days Hours Min. Social Security Number 6. Sex 12 Months Days Hours Min. Social Security Number 6. Sex 12 Months Days Hours Min. Social Security Number 12 Months Days Months	1
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Usuel Residence of Decedent 04/03/1931 PA	place (State or Foreign untry)
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N 9 Bridge Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	g.
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Mrs. Pauline Patras/Wife 8 Brenda Street Port Deposit, MD 21904	p C00e)
Mrs. Pauline Patras/Wife 8 Brenda Street Port Deposit, MD 21904 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or T	own, State
20a. Method of Disposition Comparison C	
*4 Donation 5 Other (Specify) Chesapeake Crematory 2005 Beltsville, 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives	Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Service Baltimore, Management of the Pasture Baltimore, M	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death A Q Q Q S
The part of the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delive Month	rery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	
- 10 L MS ZANDI ILIBS	opsy findings available ompletion of cause of
	4.5
The state of the s	fy)
O 5 5 5 D I O No	
2 Accident investigation 2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Run City or Town, State)	al Route Number,
A because of the state of the s	
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a control of the cause (s) and manner as a control of the cause	stated. o the cause(s)
M + HAMMINOO H41069 April 17	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. STANLEY KNULLY 1308 BUSIESS (FW # 102 Edgewood Z104) 31 Date filled (Month Day Yard) 33 Peristrate Stanting	
State Registrar 31. Date filed (Month, Day, Yeàr) 32. Registrar's Signature APR 2 0 2005	ට
DHMH 17 Rev 1/2001	Ô

			1 - For State Registrar	State of M	Marylar		artmen rtificate			and M	,	giene Reg. No	201	15	13391
J. d.	Physici /Medi	cal	1. Decedent's Name (First, Middle, La: HELEN M. PAXTON								2. Date of De Month APRIL	Day 13	, 20		3. Time of Death 7:37PM M
	Examir	ner	4a. Facility Name (If not institution, give ARDEN COURTS ASS 5. Social Security Number 6. S	ISTED LIV	/ING	last birthday)		ISON	Location o		9 Date of Bir		BALT	IMOR	
	Funeral Director			☐M 20XIF	83	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nov. 5	, 19	21	Mar	lace (State or Foreign htry) yland
	or death with the Maryland tems 23a or 28a-f show sermust be notified at	Director	Maryland Baltimo	re	10c. Ci	ty, Town or Lo	Balt		e Cou	unty					0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with t 23a or 2 ust be n		10e. Street and Number 5142 Terrace Dri	ve		10f. Zip	212	36		10g. Citizen of Wha				itry?	
980	2 hours after deal aturel', or items :	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 If If Yes, Give Year or Dates	s? ∑No	l l	Was Deced f Yes, spec 1 Pes 2		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	•	14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	d within 72 hours after giene. ir then "naturel", or ite I're Medical Ever, it a	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 yrs.		or 5+)	(Give life. L	dent's Usual Occupation kind of work done during most of working DO NOT use retired) dinator						nd of Bus ing 1		at Hospital
yland (s 1 and 2 should be filed within 7 f Health and Mental Hygiene. Item 27 is marked other then "n other treumatic event, the Medi	To Be C	17. Father's Name (First, Middle, Last) Thomas Hurt						Eliza	beth	o (First, Middle, n Clint	on			
	s 1 and 2 sho of Health and Item 27 is ma other treum		19a. Informant's Name/Relationship (7 Emily E. Ellison			3203	Bran	don		Lane	Baldw:	in,	Mary	Land	21013
Baltimore,	Page ento nnt: If ry or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)		Place of Disposemetery, crem Dewell	cemet	her place ery	4	l19-		Por		osi	wn, State t, Md.
Bal	permit. Departm Importe any inju		21. Signature of Funeral Service Licenter	esch		740	. Name and D1 Be:	lair	Rd.	Lass Balt	sahn Fur imore,	nera Md.	1 Hor 2123	ne 16	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	WU	Dense	or the mode				_	rest,			Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a conseq	uence of):					<i>U</i>			•	/
8760,	cate be executed physician and the burial-transit		that initiated events c. Due to (or as a consequence of):												
O. Box 6	The law requires that the death certific. Its has been signed by the attending plage 2 should be detached for use as t	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3□	Ectopic pre Other (spe					2	3d. Date Month		ry Day Year
rds, P.	en signed b	ed by Pł	Part II. Other significant conditions co	ontributing to death	but not resi	ulting in the un	derlying ca	use giver	n in Part I.		23e. Did to				e cause of death?
al Recc	i: The law re icate has be r, page 2 shd		Repression							24a. Was a autop: perfor 1 ☐ Yes	sv	prid dea	or to com th?	sy findings available apletion of cause of	
Division of Vital Records,	or Attending Physicien: The law Iter death. Director: After this certificate has b in by the funeral director, page 2 s	tion; To Be	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpai 28a. Date of In (Month, D	jury	ER/Outpatient 28b. Time of Injury		Other	4 ☐ Nurs	sing Hon	(Check only or ne 5 ☐ Resid 8d. Describe h	ence 6		(Specif	priseir
Divisi		Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier Certifying Phy Check only Check only Continue Certifying Phy Cer	sician: To the bes iner: On the basis and manner s	or examinat	wledge, death tion and/or inve	occurred a estigation, i	t the time in my opi	, date and nion, death	place, a occurre	nd due to the cod at the time, d	ause(s) a	and mann place, and	er as sta	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Mus				D3C			1	Pod. Date	signed (Month, D	day, Year) 65
1			30. Name and address of person who	ompleted cause of		23a) (Type, P	rint)	13	MITIN	1080	· MO	21	204		
	Sta Registra		31. Date filed (Month, Day, Year)		trar's Signat	ture	de								

1. Decedent's Name (First, Middle, Last)

3. Time of Death

1:43) DM

EVANS

2. Date of Death Month

Phys	sicia edica		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		HOWARD	FARLE	Y Q	UILLIN			Manta 1	1	PE, EVA	25 1	43) PM
Exa			4a. Facility Name (If not ins Saint Jo	stitution, give Seph	street and number) Medical	Cent	er	4b. City, Tov	vn, or Locat	ion of Death	n	4	c. County of De	ath ltime	ore
Funer Direct	_		5. Social Security Number 022-01-6464	6. Se.	7. Ag	e (In yrs. Ia	st birthday) Yrs.	If Under 1 Y Months D	ear If Ur ays Hou	nder 24 Hrs. urs Min.	8. Date of Bi (Month, D 11-10-	ay, Yea.	9. B	irthplace (S Country) / IRGII	State or Foreign
p .			Usual Residence of Deced			10c City	Town or Lo	eation						10d Inc	ide City Limits
larylan show		2		BALTIMO	חר	Tod. City,	TOWN OF EC		CKEYS	/T115					Yes 2XXNo
8a-f		Director		DALITM	JKC					/1446		40- 0	Nat 6 146 4 6		
with th			10e. Street and Number 300 INTER	RNATION	IAL CIRCI	С		10f. Zip Co		1030		10g. C	itizen of What (U.S.		
sath v		Fai		CNATIO	12. Was Decedent		13	Was Decedent			acify Vas or N	0-	14. Race - An		ian
be filed within 72 hours after death with the Maryland that Hyglene. The Hyglene of the that "natural", or Items 23c or 28a-1 show event, I're Medic Escripter must be notified.		by Funerai I	11. Marital Status 1 □ Never Married 2 □ XX Widowed 4 □ Div		Armed Forces? Y Y Yes 2 1 If Yes, Give Year or Dates:	No		Was Decedent If Yes, specify			Rican, etc.)		Black, Wh		
2 hou		ted	15. Decedent's Education (Specify only highest grade completed)				16a. Dece	dent's Usual O	ccupation			16b.	Kind of Busines	s/Industry	
hin 7	ŀ	Completed	(Specify only Elementary/Secondary (e <i>compietea)</i> College (1-4or :	5+)		kind of work d			ng	R/	ALTIMORE	C	ΙΤΥ
ad with		000	,		4 YEARS			COURT	CLEF						
12 should be filed within h and Mental Hygiene. 7 is marked other than fraumatic event, the Mental Hygiene.		To Be	17. Father's Name (First, M		JILLIN	,			18. M	VIRG	First, Middle	MPLE			
and and ls my			19a. Informant's Name/Re										or Town, State		
		-	BARBARA QUIL		LLL (DAU			BOX 606			NOR I H	-		2704	
ages 1 int of H t: If ite			20a. Method of Disposition 1 XX urial 2 ☐ Crem 1 4 ☐ Donation 5 ☐ Ot	ation 3 🗆 F		cer	netery, crer	matory or other	r place)	!)~2005		Cocation - City of RKVILLE,		
permit. Pages 1 an Department of Heali Important: If item 2	once.		21. Signature of Funeral S				22	2. Name and A	ddress of F	acility			1050	YORK	ROAD
1 405 2	a	_	▶ K. W. &	wer				UCK TO					· TOWSO		21204
			23a. Part1. Enter the disea shock, or heart failure	ase, or compi e. List only o	ications that caused ne cause on each li	d the death. ne.	Do not ent	er the mode of	dying, suc	h as cardiac c	or respiratory	arrest,		Interv	al Between t and Death
Physicia	_		Immediate Cause (Final disease or condition resulting in death)		CARDI	DGENI	C SH	IOCK							
/Medic Examin	-		resulting in death)		Due to (or as			OL TNI	EARCI	TON					
		_	Sequentially list conditions		Due to (or as			Tibe A 141	TH Nov	7 (2) 4					
led le		ulu	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	ໍ ⊀	22010 (01 00										
axecu and al-tra		Examiner	that initiated events resulting in death) Last	- 1	Due to (or as	a conseque	ence of):								
te be e					d										
the death certificate be executed the attending physician and had for use as the burial-transit		/sician/Medical	IF FEMALE: 23b. Was decedent pregning in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	anı	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal c	leath 3□	Ectopic pregn					23d. Date of d Month	elivery Day	Year
that the sid by detac	i	r V	Part II. Dther significant c	onditions co	ntributing to death b	out not result	ting in the u	nderlying caus	e given in F	art I.	23e. Did	tobacco	use contribute	to the caus	se of death?
w requires that the been signed by the should be detact		ا ھ						, ,			1 🗆	Yes :	2 X No 3□1	robably	4 Unknown
aw rec		Completed									24a. Wa		24b. Were	autopsy fin	dings available
The lav		E									perf	opsy ormed? 2 A N	death?	s 2 N	n of cause of
vician: The certificate rector, pag	(0	25. Was case referred to n	nedical					26. F	Place of Death	(Check only				
Physic this ce al direc		0	examiner? 1 Tes 2 No	1	Hospital: 1 🔀 Inpatio	ent 2 E	R/Outpatier	nt 3 DOA	Other: 4	Nursing Ho	me 5 Res	idence	6 Other (Sp	ecity)	
nding Pt th. :: After the				Pending investigation	28a. Date of Inju (Month, Da	iry Year) 2	28b. Time o Injury	f 28c.	Injury at Work? 1 🗌 Yes		28d. Describe	how inj	ury occurred		
To the Hospital or Attanding Physician: The law requires that the within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the Completely filled in by the funeral director, page 2 should be detached.		Certification;	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of In building, et	jury - At hon cc. (Specify)	ne, farm, str	reet, factory, of	fice		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
e Hospita 124 hours e Funara letely fille		edicai			sician: To the best ner: On the basis of and manner st	f examination									tuse(s)
Mithir To th		Ž	29b. Signature and title of	certifier	nd	2			cense numl 3026 J				ate signed (Mon		
i1		+	30. Name and address of p	person who co	ompleted cause of o	death (Item 2	23a) (Type,								
(04)			FRANCIS K	HOO M	76	7i1 (1)	SIFP	DRIVE	TOI	VSON.	MARYL	ANI	21204	4	
	Stat	_	31. Date filed (Month, Day,	Year)	32. Registr	ar's Signatu	re	1. 1							
Reg	istra	ř		APF	32. Registr	file	was .	15. PM							

				1 - For State Registrar	State o	f Marylan	id / Depa		Health and M Death	lental Hygi	ene 2 (05	13396
	1			1. Decedent's Name (First, Middle, L	ast)			-		2. Date of Death	Day	Vasa	3. Time of Death
		Physici /Medic Examin	al	Lester Rory J. 4a. Facility Name (If not institution, g		mber)		4b. City, Town, o	or Location of Death	APRIL	16 2	Year 2005 by of Death	9,15AM
		Examin	٠.	GOOD SAMARITA	AN HOSI	PITAL		BALT	MORE				
		Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
		Director		262-64-4158	1 X M 2□ F	5.5	Yrs.	Monana Baya	1700.5	11/27/19		Flor	
		pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation				1	I Od. Inside City Limits
		sho	5	Tod. State		100.01	-	imore					ty∑Yes 2 No
		he M	Director	Maryland 10e. Street and Number			Dail			10	g. Citizen of	What Cour	
		with t	ត់					10f. Zip Code		"	-		шуг
		eath	Funeral	529 Oakland Ave:		edent Ever in U	S 13	21212 Was Decedent of I		ecify Yes or No-	U.S.	A. ce - Americ	can Indian.
		hem liner	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	.0.	If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	Rican, etc.)		ack, White,	
	336	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	V O		1 ☐ Yes 2√∑ No	Specify:		Specia	fy: B	lack
	Ö	2 hou	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation	1	6b. Kind of E	Business/In	dustry
	215	hin 7 9. Med	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of work ad)		(T) 4 T		
	2	od wil	Con	12			Bus	Operator					rtation
	pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	st)				18. Mother's Name	e (First, Middle, M	aiden Sumai	me)	
	<u>8</u>	Mend h	2	Lester Rory Sr.					Thelma				
	lar	2 sho and Ism reum	1 8	19a. Informant's Name/Relationship	(Type, Print))		t and Number or Run				
	2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be nutilied at		Lucy Rory / Wife		20h [venue, Bal				21212
	9	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Removal from	State 200. F	emetery, crei	sition (Name of matory or other pla		11	0c. Location	-	
	Ë	Pag tmen tant: jury		*4 ☐Donation 5 ☐ Other (Spec		Mt.		Cemetery					Maryland
	Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service L	S99				ess of Facility The				F/H, P.A. Land 21215
Kr Roy	P.O. Box 68760,	The private and Medical Examiner Italians and Medical Examiner Italians Ita	ical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Index in Cause (Disease or injury that initiated events resulting in death) Last	a. As Due to	each line.	juence of):		ing, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
1257		ne death certific the attending pi hed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	tcome of pregna birth 2 Feta nant at time of c	Ideath 3	Ectopic pregnanc Other (specify)	ey			ate of delive	ery Day Year
		uires that the signed by detac	y P	Part II. Other significant conditions	_		_		ven in Part I.	23e. Did toba	acco use con	tribute to th	ne cause of death?
	ğ	w require been sig should b	ed	END STAGE	RENAL	- DIS	EASI			1 ☐ Yes	2 □ No	3 Prob	bably Unknown
	Division of Vital Records,	The law requite has been age 2 should	Completed by	CORONARY	RTER	7 Dis	EAS	ξ		24a. Was an autopsy perform	24b. ed? □ No	Were auto prior to cor death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
	ita	yaician: The l is certificate ha director, page	a)	25. Was case referred to medical					26. Place of Death				
	† \	Physic this ce al direc	To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2□	ER/Outpatier	nt 3 DOA	her: 4 Nursing Ho	me 5 ☐ Resider	ice 6 □Oti	her (Specif	y)
	o uc	ding Pt. Atter the		27. Manner of Death 1		of Injury th, Day Year)	28b. Time o Injury	f 28c. Inju Wo	iry at ork?] Yes 2 □ No	28d. Describe hov			
	/isic	Attend r death ector: /	Certification;	3 ☐ Suicide 6 ☐ Could not	be 28e. Place	of Injury - At h	ome, farm, sti	reet, factory, office		28f. Location (Stre		ber or Rura	i Route Number,
	D	tal or A rs after al Direc ed in by	Cert	4 Homicide	build	ing, etc. (Specia	y)			City or Town.	State)		
		To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying I (Check only 2 Medicel Ex	eminer: On the b	a best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	ime, date and place, opinion, death occurr	and due to the cau ed at the time, dat	use(s) and m te and place,	anner as si , and due to	ated. the cause(s)
		To the I within 2 To the I complet	¥	29b. Signature and title of certifier	200.	MO			se number		d. Date signe		Day, Year)
	,	1	/	1 6 15 gay	ceay)	1010			5306		1116,	102	
	1	118		30. Name and address or person wh									
	_	1'		31. Date filed (Month, Day, Year)	RJEILY,	5601 1	OCH F	CAVEN B	BLUD, BA	LTIMORE	, ME	212	39
ľ		Sta Registr		A	PR 2 0 2	05 <i>E</i>	Augs .	B. Apar					

Walter Rudolph 4/17/05 7:45 PM

			Piease	Type or Pri				ik. Assure		_	ble.	
					, ,	•	tificate o		pin 1	Reg. No.	15	13397
	Dhuninia		1. Decedent's Name (First, Middle, La	st)	-				2. Dete of D	eeth Dav	Year	3. Time of Death
	Physicia /Medic		Walter Ed	win Rudolph	Sr				April 1			7:45 pm
	Examin	er	4a Facility Name (If not institution, giv	e street end number)				4b. City, Town, or				
	-		Oak Crest 5. Social Security Number 6. 5	ex 7. Ac	e (In vrs.	lest birthdey)	if Under 1 Ye	Baltimore or If Under 24 Hrs		Baltim		ece (Stete or Foreign
	Funeral Director			OM 20 F 8		Yrs.	Months Da	ys Hours Min	. (Month, D	v 25 1 916	Country Baltin	nore, Maryland
	P		Usual Residence of Decedent						7 000 2232	, == 1,20		
	ahow	-	10a. State 10b. County			ty, Town or Loc					100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the Maryle or 28a-f sho	Director	Maryland Baltimore 10e. Street and Number		Da	ltimore (10f. Zip Cod	Δ		10g. Citizen of	What Countr	Λ
	를 즐겁	₫	3901 Hannon Court Apt	2C			21236			USA		•
	ter death tems 2: iner_mus	Funeral	11. Marital Status	12. Was Decedent	Ever in U	,S. 13. V		of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or N		e - America	
9	or its		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 X Yes 2 1 If Yes, Give	No		Tes, specify C		no rucan, etc.)	Specifi	ck, White, et	ic.
003	n 72 hours "netural",	d by	3 Widowed 4 Divorced	Year or Dates:	WI	<u> </u>					Whit	
15	in 72	Sete	15. Decedent's Ed (Specify only highest gre	de completed)		(Give I	lent's Usual Oc kind of work do DO NOT use rel	ne during most of wo	orking	16b. Kind of B	usiness/indi	Jstry
212	2 should be filed within end Mentel Hygiene. Is marked other than aumatic event, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 9	5+)	Artist	Supervis	sor		Social S	ecurity	Administ.
pu	be filed tel Hyg d othe event,	Bec	17. Father's Name (First, Middle, Lest,						me (First, Middl	e, Maiden Surnan		
yla	should bind Ment	2	Walter Ernest Rudolph					Caroline				
Nar	gas 1 and 2 should be filed within to f Health end Mentel Hygiene. If frem 27 te marked other than or other traumatic event, The Mentel trauma		19a. Informant's Name/Relationship (Type, Print)				eet and Number or F		-		
e,	1 end Health em 27		Elma Mae Rudolph 20a. Method of Disposition		20b. F	Place of Dispos	annon Cou		Date Date	nore, Mary		
nor	Pagas nant of I nt: If Ita		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		- 0	cemetery, crem	natory or other p	cem. April		Baltimon	0586	
3altimore, Maryland 21215-0036	교 든 큰 글	ł	21. Şignature of Funeral Service Licer		1 00	22.	Name and Ad	dress of Fecility		Darwind	e, rary	iau
ä	Deperiment important		Mosh Aroch	Chris	N	1		neral Home I Road Baltin		l. 2122	<i>c</i>	3.
		\dashv	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the deat	h. Do not ente	or the mode of o	dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			nson's	_	sease				Onset and Death
		<u>-</u>	resuming in dealing		Due to (d	or es a consequ	uence of):				1	
	ecuted end I-trensit	amlner	Sequentially that conditions	b	Due to (c	or es e consequ	neuce of).					
ó			Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury		0,000	,, 00 0 00,,004,	301,00 01,					
Box 68760,	ate be hysici the bu	lcal	Ceuse (Disease or injury that initiated events resulting in death) Last	C	Due to (o	r as a consequ	uence of):					
9 ×	ding p	Mer.		d							!	
	Attanding Physician: The law requires thet tha death certificate be exact death. actor: After this certificate has been signed by the ettending physicien or that tuneral director, pege 2 should be datached for use es the buriel.	Physician/Medical E										
P.O.	tha de ny the ached	hysi	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the un	iderlying cause	given in Pert 1.		d tobacco use co ∃Yss 2⊡No		the cause of death?
	s thet med b	P P								7 2 2 1 1 0	0_11020	.b., 4_ e
rds	en sig	be							24a. Wa	s an autopsy formed?	avai	re autopsy findings ilable prior to
ပို	law re as be	Completed									of de	pletion of cause eath?
<u>=</u>	The sate h	Con							90	Yes 2CM	10	Yes 2 No
Vita	lclan: Sertific	Be	25. Was case referred to medical examiner?	Hospital:				Other	ath (Check only			-
ot	Phys this rat di	၉	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	1 LI Inpatie		ER/Outpatient 28b. Time of	I 3 DOA	4 Nursing		sidence 6 Oth		
O	dling th. After	盲	1 ☑Netural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, De	y Year)	Injury		Nork? □Yes 2□No		. ,		
Division of Vital Records,	는 다음 다	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Plece of Inj building, et	ury - At h	ome, farm, stre y)	eet, factory, offi	ce	28f. Location City or To	(Street end Numbown, Stete)	per or Rural	Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Exam	ysician: To the best of	examina	wledge, deeth	occurred at the	time, date end plec by opinion, death occ	e, and due to the urred at the time	e ceuse(s) end ma	anner as sta and due to t	ited. the cause(s)
	thin 2, the fundamental	8 E	29b. Signature and title of certifier	and menner sta	ated.		29c. Lice	ense number		29d. Date signe	d (Month, D	Pey, Yeer)
	\$ _ \le \(\)		^ ^	. <		εΛ	~	51//11/		۸ .۱	14	7005
6	241	-,	30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type, F	Print)	18676)	1.29 H	13	2007
"(O'A.		Anna Monias	8800 W	alth	ver B	buleva	rd Pail	(ville	MD ?	312.	34
	Stat Registra	_	31. Date filed (Many P. Pey 2 (1987) 20	3. Registr	ar's Signe	eture	ونا					

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			1- For State of Maryland / Department of H			6. U	05	13398
			negistrar 1. Decedent's Name (First, Middle, Last)	Journ	2. Date of De	Reg. No.		3. Time of Death
	Physici	an			Month	Day	Year	5 00 715 M
4.	/Medio Examin		Eugene Jacob Rye 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or	r Location of Death	04		2005 nty of Death	5:20 AM
	Examin	ier						
-	Funeral			ore If Under 24 Hrs.	8. Date of Bir (Month, Da	th	1timor 9. Birthp	place (State or Foreign
	Director		213-36-8254 1M 2 F 72 Yrs. Months Days	Hours Min.	03/08/	1933		vland
	pc ,		Usual Residence of Decedent					
	arylar show	_	10a. State 10b. County 10c. City, Town or Location				1	10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	cto	MD Baltimore Baltimore					
	thin 72 hours after death with the Maryland e. an "natural", or Itams 23a or 28a-f show Medical Evant must be notified at	Director	10e. Street and Number 10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	s 23s	ral	4101 Baker Lane 21236		" "	U.S		Indian
	er de Itam	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecity Yes or No Rican, etc.)	14. H	łace - Americ Black, White,	
5	rs aft	by F		Specify:		Spec		
9500-61212	tura stura	ed	15. Decedent's Education 16a. Decedent's Usual Occup.	ation		16b. Kind of	Whi Business/In	
<u>.</u>	within 72 ene, than "nai	Completed	(Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired. Elementary/Secondary (0-12) College (1-4or 5+)	during most of worki d)	ng			
717	3 6 € 5	mo	12 WElder			Lafar	ae Co.	
	other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle			
yland	Aenta Aenta rked ric e	ToE	Jacob Rye	Emma U]	lrich			
Mary	should and Men s marke numatic	Ι.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a	and Number or Rura	l Route Numb	ər, City or Tou	vn, State, Zip	Code)
	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		Sylvia Rye 4101 Baker Lar	ne - Balti	more.	Marylar	nd 21	236
<u>e</u>	of Hea		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State		ate		n - City or To	own, State
Ĕ	Pages ment of tant: If it lury or o		`4 □Donation 5 □Other (Specify) Parkwood Cemetery	04/20	/2005	Baltim	ore.M	arvland
Baltimore,	permit. Departr Importa any infe		21. Signature of Funeral Service Licensee 22. Name and Address					Home, P.A.
n —	89 5 2 9		11750 Belan					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	g, such as cardiac c	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a metastatic Colon Cal	rcinoma				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				- 1	
	Examiner		Sequentially list conditions					
-	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last					
/60	ate be executed hysician and the burial-transit	a E	resulting in death) Last Due to (or as a consequence of):					
	cate b	2	d					
D O X	leath certificate ettending phys I for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy					
X Q	ath tter	lan	23b. Was decedent pregnant in the past 12 months?				Date of delive Month	ery Day Year
	0 0 0	ysic	1 Yes 2 No 9 Unknown 9 Unknown					
7.	requires that the dei nean signed by the e hould be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did t	obacco use co	ontribute to th	he cause of death?
g,	signe d be	d by	Consentine heart Failine		10	res 22 No	3 Prob	abiy 4 ∐¹Unknown
Sora	ee noc	etec	a lota molit		04. 146	-	. 101	
é	2 2 8	Completed	Disvetto menus		24a. Was autor		prior to cor death?	psy findings available mpletion of cause of
	ate pag		Renal in Sufficiency		1 ☐ Yes	28 No		2 No
VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death				
0	Phys this al di	٠ <u>۲</u>	1 Tes 28 No 1 Inpatient 2 EH/Outpatient 3 DOA	4 🗆 Nulsing Hor	ne 5 A Resi 28d. Describe I			y)
	Jing After fune	tlon	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work	k?` Yes 2 □ No		ion injury out		
UIVISION	or Attending after death. Director: After in by the fune	Ilca	3 Suicide 6 Could not be		28f. Location (Street and Nur	mber or Rura	al Route Number,
<u> </u>	in Dirt	Certification:	4 Homicide determined determined building, etc. (Specify)		City or Tox			
	Hospital 24 hours a Funeral i		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time	ne, date and place, a	and due to the	cause(s) and	manner as s	tated.
	Ho 24 h Fui etely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.	pinion, death occurre	ed at the time,	date and place	e, and due to	the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier 29c. License	e number		29d. Date sign		Day, Year)
	1	0/	Bridgerd 2. Elset NO 0453	568		4/19/	105	
2	X /6	1	A			.1.11		
) /(BRAD EBRIGHT 9524 Below Rd BA	CT, MO	21236)		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registr	ar	APR 2 0 2005 Bloom & April					

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	5 13399
	Physici /Medio Examin	al	Millaved Kidges 4 15 05	5 1930 M
	Funeral Director	ei I	umms Baltimore	Birthplace (State or Foreign Country)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location RANDALLSTOWN	10d. Inside City Limits †∑ Yes 2 □ No
	th with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 7404 RIPPLE CT. 10f. Zip Code 21244 USA	
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational bunciliad at	by	3 Wildowed 4 Divorced Year or Dates:	American Indian, White, etc. LACK
21215-0036	d within 72 ho piene. r than "natu ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	ess/Industry
Maryland 2	should be filed withir ind Mental Hygiene. s marked other than umatic event, Ire M	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ULYSSES DUNCAN MARY GRIFFIN	to Tim Code)
	tand 2 si Health and tem 27 is r		19a. Informant's Name/Relationship (Type, Print) ALBERT RIDGES/HUSBAND 7404 RIPPLE CT., BALTO, MD 21244	te, Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal important: if item 2 any injury or other once.		20a. Method of Disposition 1	, MD
Baj	Depar Impor any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & Service Licensee 1701 LAURENS STREET, BALTO., MD 2	
	Physician /Medical Examiner	Examiner	23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause. Obsesse or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death
P.O. Box 68760,	that the death certificate be executed of by the attending physiclen and detached for use as the burial-transit	Physician/Medical E	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Ab 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy Month 5 Other (specify) Month	Day Year
	law requires fhat the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death out not resulting in the driderlying cause given in Part I.	Probably 4 Unknown
Vital Records,	The ate h page	e Completed		
of Vil	S S 5	To B	examiner? 1 Yes 20 No Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Division c	Attending P r death. ector: After t by the funera	Certification:		
DİXİ	ital or Attendurs efter deathral Director:			
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: Atter th completely filled in by the funeral	dedicai		due to the cause(s)
)	o 1 with C noo	34	29b. Signature and title of certifier 29c. License number 29d. Date signed (N 4/15	t5
4	51		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HJONG NG-YEN 23 S, Green St Backing	ne, MD 2/26
	Sta Registi		The state of the s	

				aryland / Dep		Health and I	Mental Hyg	_	5 131.00
	Physici /Medi		1. Decedent's Name (First, Middle, Last) 1 OMGS RODRIGUEZ				2. Date of Deat Month	Day Year	
	Examir		4a. Facility Name (If not institution, give street and number, University of Manyland Medi	cul Center		or Location of Death	Δ	4c. County of De	
	Funeral Director		5. Social Security Number 136-32-6142 Usual Residence of Decedent	90 (In yrs. last birthday)	Months Days		8. Date of Birth (Month, Day, April 2	,1915 Ar	rthplace (State or Foreign Country) gentina
	he Marylan Ba-f show criffed et	ector	10a. State 10b. County MD Anne Arundel	10c. City, Town or Lo	a Park				10d. Inside City Limits 1 ☐ Yes XX No
	with ti	Dire	10e. Street and Number		10f. Zip Code	011/6	10	og. Citizen of What (country?
9036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fra Medical Exercities fraist be resified at	d by Funeral Director	452 Benfield Road 11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced 12. Was Decedent Armed Forces' 12. Was Decedent Armed Forces' 12. Was Decedent Armed Forces' 12. Was Decedent Armed Forces' 12. Was Decedent Armed Forces' 13. Was Decedent Armed Forces' 14. Was Decedent Armed Forces' 15. Was Decedent Armed Forces' 16. Was Decedent Armed Forces' 16. Was Decedent Armed Forces' 16. Was Decedent Armed Forces' 17. Was Decedent Armed Forces' 17. Was Decedent Armed Forces' 18. Was Decedent Armed Forces' 18. Was Decedent Armed Forces' 19. Wa			21146 Hispanic Origin? (Soan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	USA 14. Race - Arr Black, Wh Specify:	
Maryland 21215-0036	TI 75 5 5	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 2	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Busines. U.S. Army	·
pu	0 = 0 >	Be C	17. Father's Name (First, Middle, Last)		· ·	18. Mother's Nan	ne (First, Middle, N		
ryla		^C	Antonio Rodriguez	405 14-7		1	a Yglesia		
Ma	nd 2 silith ar		19a. Informant's Name/Relationship (Type, Print) Virginia C. Rodriguez (Wi	1				City or Town, State, rk, MD 21	
Baltimore,	2		20a. Method of Disposition 1	20b. Place of Disponentery, cres	osition (Name of matory or other pla	ace)	Date 2	Oc. Location - City o	r Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22	Name and Addre Hardesty 12 Ridge	ess of Facility Funeral 1y Avenue	Home, P.A		
	Physician /Medical Examiner	er	if any, leading to immediate Due to (or as	a consequence of): Renal Fall a consequence of):		ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
68760,	death certificate be executed a attending physician and d for use as the buriat-transit	edical Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last C	a consequence of):		-			
P.O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did toba	1	o the cause of death?
	The ate ha	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of s 200 No
		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ent 2□ER/Outpatien	it 3□ DQA Ott		th Check onl one	nce 6 □Other (Spe	
	ding h. After fune		27. Manner of Death 1 Whatural 5 Pending 2 Accident investigation	ry 28b. Time of	28c. Inju	4 🗆 Nutsing H	28d. Describe how		(City)
Division	itel or Atters as atters de al Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injuriding, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	4	28f. Location (Stre City or Town,	eet and Number or A State)	ural Route Number,
	To the Hospitel or Attenwithin 24 hours after deating to the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	rexamination and/or inv	vestigation, in my	opinion, death occur	rred at the time, da	te and place, and du	e to the cause(s)
	To With		29b. Signature and title of certifier William Winchconsh			6602	29	d. Date signed (Mon 4/17/0	
je)('		30. Name and address of person who completed cause of different and the second	eath (Item 23a) (Type.	Print) ivensity	of Many la	ind Balt	imone, n	N
Pull	Sta Registr	-	APR 2 0 20		L. A	nete			

			1 - For State Registrar	State	of Maryla		artment rtificate			ind M	ental Hy	gieņe	005	31	01
	Dhusis		1. Decedent's Name (First, Mide	dle, Last)							2. Date of De Month	eath		3. Time	of Death
	Physic /Medi		Michael	C1	ifford		F	Ross			April	Day 14		3:42	2 a ^M
	Exami		4a. Facility Name (If not instituti	-	number)		4b. City, To	wn, or L	ocation of	f Death		4c.	County of Dea		
			358 Cokeland	+				re1					Anne Ai		
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F		s. last birthday) Yrs.	If Under 1	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di	rth ay, Year)	9. Bir	thplace (State	or Foreign
	Director		578-48-8638 Usual Residence of Decedent		68	113.					March	18,1	937 Nev	York	
	yland		10a. State 10b. Count	ty	10c. C	ity, Town or Lo	ocation							10d. Inside	City Limits
	Mar ilied	to	MD Anne	Arundel		Laure	1							1 □ Ye	s 2 XNo
	th the	irec	10e. Street and Number				10f. Zip Co	ode				10g. Citiz	zen of What Co	ountry?	
	death with the Maryland ms 23a or 28a-f show Liviust to mulified at	<u>a</u>	358 Cokeland	South				207	24				USA		
	r dea	by Funeral Director	11. Marital Status	Armed	ecedent Ever in I Forces?	J.S. 13.	Was Deceden	t of His	panic Orig	in? (Spe	cify Yes or No		4. Race - Ame Black, Whit		
36	s afte	y FL	1 Never Married 2 Ma	rried 1X Yes	2 □ No Give	1	1□Yes 2K	_	Specify:		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			White	
21215-0036	72 hours after death with the Marylar "naturel", or Items 23a or 28a-f show cited Exerrative friest by notified at		3 Widowed 4 Divorce	ont's Education	Dates:	1 100 D									
5		Completed	(Specify only high	est grade complete		(Give	dent's Usual C kind of work of DO NOT use i	ocupati done du retired)	ion ring most	of working	g	16b. Kir	nd of Business	Industry	
212	y within piene. r than "	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)		ter Pr						IRS		
	e filed Il Hyg other	Be C	17. Father's Name (First, Middle	, Last)		, , , , , ,				-	(First, Middle	, Maiden .			
<u>a</u>	should be filed withir ad Mental Hygiene. marked other than imatic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Office of the Mental Offi	To B	Clifford Byro	n Ross					Marv	v .	Steven	S			
Maryland	2 sholl and N is ma	Γ.	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	ng Address (S	treet an					Town, State, 2	Zip Code)	
	s 1 and 2 should be filed within f Health and Mental Hyglene. Item 27 is marked other than other traumatic event, the M		Sadako Ross (Wife)		358	Cokela	nd S	South	, La	urel,	MD 20	0724		
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2XX remation	3 □Removal from		Place of Dispo cemetery, cren	sition (Name natory or othe	of r place)		Di	ate	20c. Loc	ation - City or	Town, State	
Baltimore	tment tent:		'4 □Donation 5 □ Other (Specify)		etro Cr		*		-19-2	2005	Balt	imore,	MD	
Bal	permit. Pag Department Importent: i any njury o		21. Signature of Funeral Service	9	•		Name and A Hardes 12 Rid	ty I gely	Tuner V Ave	al H	ome,P. Annap	A olis,	MD 21	401	
н			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that st only one cause on	caused the dea each line.	th. Do not ente	er the mode o	f dying,	such as c	ardiac or	respiratory a	rrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	love	K	fa	1	lu	20	>			Onset and	Death
	/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):	-	0	/ .	/ .	. 10			W.	
1		L .	Sequentially list conditions,	b. Due to	o (or as a consec	Zuence off:	m	eq	asi	RU	tes		-	-4-	non.
	uted Insit	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	lu	no	C	a	UK	رم				3 1	ronto
Ć	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	CDue to	o (or as a consec	queface of):									
8760	sate be shysicia the bur	dical		d	Cos	and	sy	6	289	les	4	de	ffea	SPI	O gen
9	rtifica g ph as th	Medi	I S S S A A A A A A A A A A A A A A A A												
O. Box	The law requiras that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregn birth 2 Feta gnant at time of c nown	al death 3	Ectopic pregn Other (specif					23	Sd. Date of delimenth	very Day	Year
4	that the ed by detac		Part II. Other significent conditi	ions contributing to	death but not res	sulting in the un	deriving caus	e given	in Part I.		23e. Did to	obacco us	e contribute to	the cause of	death?
Records,	w requiras been sign should be	ted by									11			bably 4 🗆	
ec	has b	Completed								_	24a. Was autop		24b. Were aut	opsy findings ompletion of	available
E		Con									perfo	rmed? 2 No	death? 1 ☐ Yes	2□ No	Jud 30 0.
Vital	sicien: certific rector,	Be	25. Was case referred to medica examiner?					-	6. Place o	f Death	Check only o	ne).			
of	shys al di	2	1 Yes 2 No		Inpatient 2			Other:	4 🗌 Nurs				Other (Spec	ify)	
uc	ter ter	lon	27. Manner of Death Natural 5 Pendi		of Injury nth, Day Year)	28b. Time of Injury		Injury at Work?			3d. Describe I	now injury	occurred		
Division	Attending r death. sctor: After by the fune	fical	3 ☐ Suicide 6 ☐ Could		e of Injury - At h	ome farm etro			s 2 □ No		If Location /6	Year to and	Number or Rui		-1
Ö	5 4 4 5	Certification:	4 Homicide determ	build	ling, etc. (Specif	(y)	et, factory, on	IICO		20	City or Tox	m, State)	radilipet of Hui	ai Houte Nun	nber,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) Certifying 2 Medical	ng Physician: To the Examiner: On the and man	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at the	ne time, my opini	date and ion, death	place, ar occurred	d due to the of at the time, of	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s	5)
	To the within 2 To the comple	M	26b. Signature and title of certifie	or 1/5	9		29c. Lio	cense n	umber			29d. Date	signed (Month	Day, Year)	
1	1/	/	30. Name and address of account	VU	Jupo of death //	n 03a\ (T)	Da)5°	122	8		4	18/05		
	0'		30 Name and address of person Elvira Pasma 31. Date filed (Month, Day, Year,	nik MD	Registrar's Signa	OI Lau	rel R	irk	Dr.	#33	4 La	urel	Md a	070	7
	Sta Registra		Λ.Ε.	P 2 0 200	Sugnation of Signa		Span								
DH	MH 17 Rev 1/20	001	Mr.	11 4 0 200	- NOWED	44	-								

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4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County	Physician		1. Decedent's Name (First, Middle, Las					2. Date of De	Day	Year	3. Time of Death
Second Security Numbers Second Security Numbers Security Numbers	/Medical Examiner		a. Facility Name (If not institution, give	street and number)		-		1			
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Separation Sep	by Fu			1 ☐ Yes 2 🔀 No If Yes, Give				o , noar, o.c.,			
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Separation Sep	d other event, Be C	1	7. Father's Name (First, Middle, Last)				_				
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Tarry Regular to immediate Due to (or as a consequence of):		9	Sequentially list conditions.	b. Stapha	1/245	bacterem	14				3 Da-3
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	nsit	i	any, leading to immediate	Due to (or as a conse	quence of):						
FEMALE:		r	esulting in death) Last	c Due to (or as a conse	quence of):						
FFEMALE: 23c. If yes, outcome of pregnancy 1 1 1 1 1 1 1 1 1	di g			d							
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	To To	2	. 11	V							
			worth 1	eoze-		1/	カンン/		APRI	211	, 2005

			1 - For State Registrar	State of N	Maryland / De		Health a	and M		iene	05	13403
	Physici	ian	1. Decedent's Name (First, Middle		SILVER				Date of Death Month	Day	Year	3. Time of Death
	/Medi Examir		WILBER 4a. Facility Name (If not institution	· ,		4b. City, Town, o	or Location o	of Death	APRIL	40 COUR	2005 ty of Death	4.224 W
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	Funeral Director		5. Social Security Number 237–50–1426	6. Sex 1 XM 2 ☐ F	Age (In yrs. last birthd 70 Yrs	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 4-1 7-	Year)	9. Birthp Cour	place (State or Foreign N.C.
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					1	Od. Inside City Limits
	a-feh	cto	Md. Balti	more	Randa	llstown						1 X Yes 2 □ No
	or 28	Director	10e. Street and Number	_		10f. Zip Code			10	og. Citizen of	What Cour	ntry?
	s 238	erai	9109 Liberty	Rd.	t Suprint I S 1	21133		-:-2/6	aif. Van as Na	USA		on Indian
36	be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show of other than "natural", or items 12b instilled at event, if a Madical Exa clive Linist be instilled at	by Funeral	Narital Status Never Married 2 Marr Microsoft Married Married Married Microsoft Microsoft Microsoft Microsoft Microsoft Microsoft Microsoft Microsoft Microsoft Microsoft Microsoft Microsoft	Armed Forces	No	 Was Decedent of If Yes, specify Cub 1 ☐ Yes 2√ No 	an, Mexican	gin? (Spe i, Puerto	Rican, etc.)		ace - Americack, White,	
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Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service		Greeing	22. Name and Addre			Baltim			1202
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			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	line.				r respiratory arre	st,		Approximate Interval Between Onset and Death
	Pnysician /Medical	m	Immediate Cause (Final disease or condition resulting in death)	ENI	STAGI	E DE	MEN	TIA			(0-84EARS
	Examiner				s a consequence of):	OBSTRUC	TIVE	= P	u mo Nas	u Dise	EACE !	~ 8 HEARS
	n =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	s a consequence of):							- 0 41=MCS
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60,	sate be executed physicien and the burial-transit	icai E	,	Due 10 (0) a	s a consequence or).							
687	ifficate g phys			d								
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isio	Attending Physician: r death. ector: After this certific by the funeral director,	ertification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be	njury - At home, farm,		Yes 2□N		8f. Location (Stre	eet and Num	her or Rura	I Route Number
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	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) Certifyin 2 Medical 6	Physician: To the bes xaminer: On the basis and manners	of examination and/or	ath occurred at the tir investigation, in my o	ne, date and pinion, deat	d place, a h occurre	and due to the cau and at the time, dat	use(s) and m te and place,	anner as sta and due to	ated. the cause(s)
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/	51		30. Name and address of person of NIVEDITA	BANSAL	9109	LIBERT	14	Rop	40	RAND	ALS TO	OM NM
	Sta Regístr		31. Date filed (Month, Day, Year) APR 2 0 200	32. Regis	trar's Signature	E	•					

December Search Force Force Appendix Carpo Smith Carpo Smith Carpo C				1 - For State Registrar	State of Ma		artment of I	Health and M <i>Death</i>		ene g. No.2005	131.01.
40 - Country of Ceath Fame All Formation				Decedent's Name (First, Middle,		Carol S	mith		2. Date of Death Month	Day Yea	3. Time of Death 7:19 p. M
Second Security Pumper 1409-044-0522 1				4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death			
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Date of the control o			ļ			V			8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
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17. Part 17. Part		or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
17. Part 17. Part		s 23a								USA	
17. Part 17. Part		ltem:	nue		Armed Forces?		Was Decedent of I If Yes, specify Cub	tispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		
17. Part 17. Part	36	irs aft	by F		If Yes, Give		1 ☐ Yes 21 No	Specify:		Specify: B	lack
17. Part 17. Part	9	2 hou		15. Decedent's	Education	16a. Dece	dent's Usual Occur	pation	16	Sh. Kind of Busines	s/Industry
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NV2DIA BANSAL - 3330 WILKENS AVENUE BALIAMORE MD-2	a	10 17									2 □ No
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NV2DIA 3 AN SAL 3330 WILKENS AVENUE BALIAMORE MD-2	Ö	s afte	Cert	4 Homicide	building, etc. (Specity)		7.1	City or Town, S	State)	
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O NIVEDIA BANSAL. 3330 WILKENS AVENUE BALTHMORE MD-2	7							67848	P	MPRIL	2 2605
		3		30. Name and address of person wh			Print)	CENS AL	ENJE	BALTIM	VE MO 21229
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		,,,			Dure Mino	The store
Registrar APR 2 0 2005 Region 16 April 1			_	Į.P.	R 2 0 2005	Bearing A	Annal.	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1948 Joseph Michael Sincavage, Jr. April 05 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Days Hours Yrs. 214-38-0015 64 Director 06/20/1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 ehow od other than "naturel", or Items 23a or 28e-f ehor event, the Madical Examiner must be notified at 1 XYes 2 No Director MD Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 918 Woodhaven Court USA 21078 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 2 should be filed within 72 hours and Mental Hygiene. Is marked other than "naturel", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Self- Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Michael Sincavage, Sr. Sarah Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st ment of Health an ant: If item 27 Is 1 Terry Sincavage- Wife 918 Woodhaven Ct., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 riment R.A. Ferris & Co. 04/11/05 West Chester, PA in,ury Depar Depar Important Information Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A.) 123 S. Washington, Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cufe hyo **Physician** 440 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner inman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 □ Yes 2 □ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 1 Yes 2 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 1 🗌 Yes 2 100 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

OSEPA Division Director filled in by within 24 hours efter To the Funeral Dire ō completely

28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN OF 1000 COH

Mace A

Registrar

Medical

31. Date filed (Month, Day, Year) APR 2 0 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieria 1 5 State
Registrar AMEND ITEM #1 PER PHY G842 CP21103tejpf Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year 12:45 MM ROSETTA SIMS-TAYLOR DUXTEC /Medical TOPI 2005 71111 4a. Fecility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death **Examiner** Sohns Hopkins Baltim If Under 1 Year 1 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2XX Yrs. Director 219-50-7467 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "neturel", or Items 23s or 28a-f show dical Examiner must be nutilised at XXYes 2 □ No Director BALTIMORE **ESSEX** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 TIMBER CREEK COURT APT. L 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: if item 27 is marked other then "neturel; or Ite, and yor other theumetic event, Its Maciest Experime ury or other treumetic event, Its Maciest Experime 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ②☐No Specify: ģ Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE'S AIDE HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DENNIS BURDEN THELMA WHITTED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 TIMBER CREEK CT. APT. L BALTIMORE, MD 21221 LAWRENCE E. TAYLOR/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If ite
any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS MEMORIAL PK. 4-23-05 BALTIMORE, MARYLAND * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. re of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician octeroderma /Medical **Examiner** Pulmonary Fibrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed KESPIrator Due to (of as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 TYes director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

Kes-00

	State of Maryland / Departme		lygiene 005 13407
		te of Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last) Francis G. Shelton	2. Date of Month	Day Year
/Medical		y, Town, or Location of Death	- 18 2005 1 45 F. M
Examiner	1/2/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	en Burnie	Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	er 1 Year If Under 24 Hrs. 8. Date of Month,	Birth 9. Birthplace (State or Foreign
Director	578-42-9203 Yrs.	Nov.	26, 1933 Virginia
and	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mary February tor	Maryland Anne Arundel Severna Park		1 ☐ Yes 2 🔼 No
with the Mar or 28e-f st be notified Director	10e. Street and Number 10f. Z	lip Code	10g. Citizen of What Country?
ELTON 1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Medical Examiner must be notified at morpleted by Funeral Director	200 Baltimore-Annapolis Blvd. 21	1146	United States
36 after death or tems 23 arriver must	Armed Forces? If Yes, sp	edent of Hispanic Origin? (Specify Yes or ecify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
D36 Urs after afte	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 3 Widowed 4 Norriced Year or Dates:	2 ☑ No Specify:	Specify: White
215-0036 thin 72 hours at en natural; or Medical Exam	15. Decedent's Education 16a. Decedent's Us	ual Occupation	16b. Kind of Business/Industry
21215-00 ed within 72 hou within 72 hou within 72 hou within 72 hou within 12 hours than "nature	(Specify only highest grade completed) (Give kind of w Elementary/Secondary (0-12) College (1-4or 5+)	vork done during most of working use retired)	
L 21 21 21 21 21 21 21 21	8 Printer	18. Mother's Name (First, Midd	Publishing
and and the final H and	17. Father's Name (First, Middle, Last) Hunter Lee Shelton	Janie (unknow	
Maryland 212. Maryland 212. d 2 should be filed within th and Mental Hygiene. it is marked other than treumatic event, the M		ss (Street and Number or Rural Route Num	<u> </u>
S = 8 = 8 =	Charlene Goodman / Daughter 32453 Cor	nstitution Hwy., Loc	cust Grove, VA 22508
ore, M es 1 and 2 of Health if item 27 Ir	20a. Method of Disposition 1 □ Squrial 2 💆 Cremation 3 □ Removal from State 20b. Place of Disposition (No. cemetery, crematory or	ame of Date other place) April 21	20c. Location - City or Town, State
Imor limor Peges ment of I	'4 Donation 5 Other (Specify) Metro Cremat	ory, Inc. 2005	Catonsville, Maryland
Baltimore, permit. Peges 1 a Department of Her Importent: If item eny injury or othe page.	21. Signature of Funeral Service Licensee Kirkie 421 Cr	and Address of Facility Ey-Ruddick Funeral H Fain Hwy., S.E., Gle	lome, P.A. n Burnie, MD 21061
	23a. Part 1. Soult the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.	ode of dying, such as cardiac or respiratory	v arrest, Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	this cancer	Onset and Death
/Medical Examiner	Due to (or as a cohsequence of): I		
ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
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68760, ficate be ex physicien a sthe burial is the burial edical E)	d		
	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
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P.O. B hat the deat do by the att	9 Unknown		
IS, P.O. res that the de signed by the z be detached t by Physic	Part II. Dther significant conditions contributing to death but not resulting in the underlying		d tobacco use contribute to the cause of death?
Cord w require been si should I			Yes 2 No 3 Probably 4 Unknown
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Vit raicie s certi directo	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I	26. Place of Death (Check onl	y one) esidence 6 □Other (Specify)
on of ding Physh After this funeral di	27. Manner of Death 28a. Date of Injury 28b. Time of		e how injury occurred
isior wendin death. ctor: Af y the fur fleatlo	2 Accident investigation	1 Yes 2 No	
Division of Vital Records, I or Attending Physicien: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)		n (Street and Number or Rural Route Number, Fown, State)
spitel ours a nerel if filled	29a. Certifier Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place, and due to the	ne cause(s) and manner as stated.
Division of Vital Records, P.O. Box (To the Hospitel or Attending Physicien: The law requires that the death certify within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending comple sity filled in by the funeral director, page 2 should be detached for use a Medical Certification; To Be Completed by Physiclan/Me	(Check only one) Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
To the within to the comp	29b. Signature and title of certifier 2	9c. License number	29d. Date signed (Month, Day, Year)
	no.	V43977	april 18 2005
211	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Colore Brown	DASAGA. 7 VALTUM
State	31. Date filed (Month, Day, Year) 32. Resistrar's Signature,	of a	1100
Registrar	APR 2 0 2005 Street St Again		

			For State Registrar	State of	Maryland	•	artment of H		and Me		giene	15	13408
			Decedent's Name (First, Middle)	, Last)						2. Date of Dea	ath	0	3. Time of Death
	Physici		DORIC	S.	hall					Month	Day	Year Zec5	6:15 AM
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location o	of Death	-	4c. County		
	LXumii	Ų.	Anne Arundel 1	Medical Cer	nter		Annap	olis			Ann	e Aru	ınde1
	Funeral		5. Social Security Number		Age (In yrs. la	st birthday)	If Under 1 Year	If Under 2		B. Date of Birt	h	9. Birthpl	ace (State or Foreign
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	or 2	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of V		try?
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	er de Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 🕅 Marrie	12. Was Decede	es?	i. 13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican	, Puerto R	ify Yes or No- ican, etc.)	Blac	e - America ck, White, e	
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Ö	thon stura	ed	15. Decedent			16a. Dece	dent's Usual Occupa	ation			16b. Kind of Bu	usiness/înd	ustry
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/lar	uld b Menta rrkad ritc a	- P	Milton Jacobs					Li1	lian	Sheeli	.ne		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menial Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical ODGe.		19a. Informant's Name/Relations!	nip (Type, Print)		19b. Mailir	ng Address (Street a	a <i>nd Nu</i> m <i>b</i> e	r or Rural	Route Numbe	er, City or Town,	State, Zip	Code)
Σ	and saith		Monroe Schall	(Husband)			Edgewood	Court	, Ann	apolis	, MD 21	403	
ore	of He of He fitan		20a. Method of Disposition 1 □ Burial 2 【▼Cremation	3 □ Pamoval from Str	l ca	ace of Dispo metery, crer	sition (Name of natory or other plac	e)	Da	te	20c. Location -	City or Tov	wn, State
Ĕ	Pag ment: I ant: I		'4 □Donation 5 □Other (S)			ro Cre	ematory	†	4/16	/2005	Baltimo	re, M	D
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service I	_icensee		22	Name and Addres Hardesty	s of Facility	y ral E	Iome P	Δ		
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г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. th line.	Do not ent							Approximate Interval Between
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Вох	ath c attend for us	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal	death 3	Ectopic pregnancy				23d. Dat	e of deliver nth	ry Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	nt at time of dea n	atn 5	Other (specify)						
<u>α</u>	that the di ed by the detached		Part II. Other significant condition	ns contributing to deat	th but not resul	ting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use conti	ribute to the	e cause of death?
Records,	es De	d by	Dementa	HUDER			, , ,			1 🗆 Y	es 2 No	3 Proba	ably 4 Unknown
Ö	w requir been si should	ompleted								040 1450	0.45.3	Mara auton	an findings available
3ec	e la has je 2	шb								24a. Was a autop perfor	sv r	rvere autop prior to com death?	sy findings available apletion of cause of
<u>e</u>	ician: The l certificate ha rector, page	O										☐ Yes	2 No
Z.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			othe	200		Check only or			-
	Phys ral di	5 T	1 Yes 2 No	1 (R/Outpatien 28b. Time of	1 3 DON	4 LI NUI	-		lence 6 Oth)
no	Attanding r death. ector: After by the fune	tlon	1 atural 5 Pendin		Day Year)	Injury	Work	k? Yes 2.⊟N			,.,,,	00	
<u>S</u>	uttandii death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could r	ot bo	f Injury - At hon	ne, farm, str				f. Location (S	Street and Numb	er or Rural	Route Number.
Ω	after Dire	Certification;	4 ☐ Homicide determ	building	, etc. (Specify)	, , ,	eet, factory, office			City or Tow	m, State)		
	Hospital	<u>~</u>	29a. Certifier 1 Certifyin	g Physician: To the be	est of my know	rledge, death	occurred at the tim	e, date and	d place, an	d due to the c	ause(s) and ma	nner as sta	ated.
	a Ful	dic	(Check only 2 Medical I	examiner: On the basi and manner	is of examination	on and/or in	estigation, in my op	oinion, deat	th occurred	I at the time, o	date and place, a	and due to	the cause(s)
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	1 /	/.		29c. License	number	_	2	29d. Date signed	(Month, E	Day, Year)
	_	/	Sty	1/2 1-K	Test.		D	386	87	_	4/13/	2001	5
1	11		30. Name and address of person	who completed cause	of dauth (Item	23a) (Type,			· · · · ·				
1	,		CTPITEN KAT	2. mn	31 80B	WSON	READ .	SEVER	no 6	ARK.	m0 21	146	
	Sta	te	31. Date filed (Month, Day, Year)	DR 9 n 3的問題	istrar's Signatu	ire A	Print) Rest	1					
	Registr	ar	AI	11 20 2000	Justin	الدائل الصياف	1						

			1 _ State	partment of Health and Nertificate of Death	Mental Hygie	ne
		W.	Registrar 1. Decedent's Name (First, Middle, Last)	erillicate of Death	Reg.	
	Physici /Medi		Robert Smyter		Month	Day Year 3. Time of Dealth
) :	Examir			4b. City, Town, or Location of Death		4c. County of Death
eş.			The Johns Hopkins Hospital	Baltimore C	ity	n/a
2	Funeral Director		5. Social Security Number 212-48-2505 6. Sex 1 M M 2 T F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov9, 194	9. Birthplace (State or Foreign Country)
76			Usual Residence of Decedent		NOV9,194	49 Maryland
	arylar ehow	7	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	er death with the Marylan Items 23c or 28e-f ehow Items be rediffed at	Director	Md n/a Balti			1XOX'es 2 □ No
	3e or	D	2106 Fleet Street	10f. Zip Code 21231	10g.	Citizen of What Country? USA
	death	Funeral	11. Marital Status	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	at a	by Fu	1 □ Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Black, White, etc. Specify: White
215-0036	72 hours 'naturel', Jicel Ex	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	104	
را2 ا	within 72 ho iene. • then "natur he Medical	Completed	(Specify only highest grade completed) (Gingle Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ring	o. Kind of Business/Industry
7	ygiene /giene ier the	Com	12th Cons	struction Worker	. (Construction
and	be fill htal Hy ad oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	,
>	thould id Men marke matic	ည		Regin		
Z Z	nd 2 salth ar 27 le 27 le r trau			06 Fleet Street		
Ç,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition 20b. Place of Dis	The second secon		Location - City or Town, State
Баппро	Page ment o ent: If ury or		TE-Durial 2 Cremation 3 Helinoval nom State	Heart of Jesus 4/19	9/05 Ba	altimore, Md.
g n	permit. Pages Department of Importent: If is eny injury or once.					i Funeral Home,PA
	* * -					e, Maryland21224 Approximate
Ų,	Physician	_	23a. Part1. Enter the dispase, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final		P V	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Head truynd Due to (or as a consequence of):	Secondary to	tall	5 hours
	Examiner		Sequentially list conditions, b. Anoxic brain	10/214		5 hours
	ied isit	nine	thany leading to inneclate Dise to (or as a consequence of):	f cervical spir		10-10-10
7	execu n and ial-tra	Examiner	that initiated events resulting in death) Last C. CanSection O Due to (or as a consequence of):	1 cervicus pir		MB 40017
0/0/	icate be executed physician and s the burial-transit	dlcal	d			CENT)
		Med	IE FEMALE:		11 34	OEMINE COMIN
מסמ	res that the death certific igned by the attending p be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 montbs? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the	□Ectopic pregnancy	A OBNORADA	23d. Date of delivery Month Day Year
j .	the de	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	☐ Other (specify)	ADIGEM WEDICA	Jay 75a
r.	s that med b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part taning the	23e. Did tobacc	to use contribute to the cause of death?
ecords,	w require been sig should b	ted t			1 ☐ Yes	2 ☐NO 3 ☐ Probably 4 ☐Unknown
<u>.</u>	law r nas be e 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ר ושווי	icate I	ပိ			performed?	/ death?
=	eiciar certif irecto	o Be	25. Was case referred to medical examinar? 1 'E' es 2 □ No Hospital: 1 □ Thoatient 2 □ EB/Outpatient	Other	(Check only one)	
5 i	g Phy er this eral d	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time	#IL 3 DOA 4 Nursing Hor	me 5 Residence 28d. Describe how in	6 ☐Other (Specify)
5	auth. or: Aft he fun	Certification;	1 Natural 5 Pending (Month, Bay Year) Injury 2 Accident investigation 13.205 11.00	A-M 1XYes 2□No -	subject fe	Il down elevator
	or Att	rtifi	3 ☐ Suicide 6 ☐ Could not be determined 2 e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	pitel ours at ours at ours at ours at ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours at our our ours at our ours at our our our our our our our our our our		200 Cariffor 17 Table 2 Physics I I gruss Store	, -	2101 Fleet S	T, Baltmore, MD
:	To the Hospitel or Attending Phyeician: The law requires that the death certif within 24 hours after death. To the Funderal Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifler 1 ☐ Certifying Physician: To the best on my knowledge, dea (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
1	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	1	Date signed (Month, Day, Year)
	1 1		Lisa Marcuca, MO	Res-000	Ap	1113, 2005
	3+1		30. Name and address of person who completed cause of death (Item 23a) (Type Lisa Marcucci Goo North Wo	Print)		
3	Sta Registra		31. Date filed (Month, Day, Year) APR 2 0 2005			

Physician Examiner of Vital Division

death certificate be executed been has this certificate After or Attending death.

the attending physician and hed for use as the burial-transit page 2 should be Il Director: / filled in by To the Hospital within 24 hours a To the Funeral C completely filled

Physician

/Medical

Examiner

Directo

δ

Completed

Be

Funeral

Director

ed other than "natural", or items 23a or 28a-f shows event, the Madical Examiner must be notified at

the Maryland

STANTON

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Baltimore, Maryland 21215-0036

es 1 and 2 should be fill of Health and Mental H fitem 27 is marked oth

permit. Pages
Department of H
Important: If ite
any injury or of

/Medical

Examiner

Physician/Medical

δ Completed 25. Was case referred to medical examiner? Be 27. Manner of Death Certification: 1 Natural 2 Accident 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier CHAMION OLIVIER

29c. License number MD RES 000 29d. Date signed (Month, Day, Year) APRIL 2005 16

MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVEN BLVD. BALTIMORE 5601 LOCH

31. Date filed (Month, Day, Year)

APR 2 0 2005



DHMH 17 Rev 1/2001

State

Registrar

			1 - For State Registrer	State of I	Marylan		artment of H				711	0.5	13411	
			Decedent's Name (First, Middle,	Last)			imodio or	Death		te of Death	, No.	00	3. Time of Death	_
	Physici		Mary Grace	Shaw					Mo	onth	Day	Year	10:35am	
	/Medio		4a. Facility Name (If not institution,		ər)		4b. City, Town, o	r l ocation	Apr	11 .		2005 ty of Death	10:00	_
	LAdiiii		1324 Middlefo					svill					0.50	
	Funeral				Age (In yrs. I	ast birthday)	If Under 1 Year			te of Birth	D	altim	olace (State or Foreign	
	Director		216-36-6534	1□M 2 ⊠ F	97	Yrs.	Months Days	Hours	Min. (Mi	onth, Day, Y	'e <i>ar)</i> 1907	Mary	ntry)	,
	ס		Usual Residence of Decedent						1500	. 0,	1707	liai y	Tanu	-
	nylan how		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	e Ma	Director	Maryland Balti	more		Cat	onsville						1 ☐ Yes 2X No	
	th th	lire	10e. Street and Number				10f. Zip Code			100	g. Citizen o	f What Cou	ntry?	
	within 72 hours after death with the Maryland ene. than "naturel", or itema 23a or 28e-f show Le Modical Examiner mast burnctified at		1324 Middleford	Road			2122	28			U.S	.A.		
	ema err	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S		Vas Decedent of H	ispanic Ori	igin? (Specify Ye	s or No-		ace - Ameri		_
36	or it	F.	1 Never Married 2 Marrie				I ☐ Yes 2፟፟ No	Specify:		oic.)			etc.	
21215-0036	nours urei',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates	s:			Opocny.			Spec	Whi	te	
7	nat nat	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	lent's Usual Occup kind of work done	durina mos	t of working	16	b. Kind of	Business/In	dustry	
7	withir ne. han	E D	Elementary/Secondary (0-12)	College (1-4c	or 5+)		OO NOT use retired	1)						
	filed v Hygie othar t		17. Father's Name (First, Middle, La	L L		H	omemaker	40 14-4-	d. N /5: 4	10.10		Home		
ä	ntal hed	Be		,					er's Name (First,		iden Suma	ime)		
Ë	should nd Men marke umatic	ို	John McCummin 19a. Informant's Name/Relationshi	_		405 14-15			Le C. Mo					
Maryland	d 2 sho						g Address (Street				-			
	1 and Health em 27 ther tr		Timothy L. Shaw 20a. Method of Disposition	(Son)	20b. Pl	1413	N. ROIII sition (Name of	ng Ro	oad Cat			Mary 1 - City or To	and 21228	_
ية	Pages nent of int: if it		1 X Burial 2 ☐ Cremation 3		te C6	emetery, cren	natory or other place				C. LOCATION	i City of Te	JWII, State	
altimore,	it. Partme		* 4 □ Donation 5 □ Other (Spe		New		dral Cem		-22-200	5 Ba	altimo	ore, l	Maryland	_
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked othar than "naturel", or itema 23s or 28e-f show any riqury or other traumatic event, the Medical Examiner is set by multipled at ODGs.		21. Signature of Funeral Service Li	A A	_	นู้ เ	Name and Addres	eral	y Home of	Cator	nsvil	le. In	nc. land 21228	
	*		23a. Part1. Enter the disease, or c	omnlications that caus	ed the death	Do not ente	30 Edmon	dson	Ave. Ca	tonsv	ille,	Mary		
١.			shock, or heart failure. List or Immediate Cause (Final	ily one cause on each	line.	. Do not ante	or the mode or dyin	y, such as	cardiac or respi	atory arrest	•		Approximate Interval Between Onset and Death	
	Pnysician / /Medical		disease or condition resulting in death)		ria								monsles	
	Examiner			Due to (or a	as a consequ	ence of):	norrhag		2					
l.		<u>m</u>	Sequentially list conditions,	b. Color	ecto	EDCE OF	norrhag	0 0	ause 0	NAETE	rmin	100	month	-
	ted	n in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequ	ence of):								-
8760,	cate be executed physician and the burial-transit	dicai [
89	fficate g phy as the	edic		U										
Вох	eath certific attending p I for use as	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnar	ncy					23d D	ate of delive	anv	
m	atte d for	Physician/M	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant			Ectopic pregnancy Other (specify)					onth	Day Year	
o.	that the di ed by the detached	lys	9 Unknown	9□ Unknown										
J.	res that igned b be deta	by PI	Part II. Other significant condition	s contributing to death	but not resu	lting in the un	derlying cause give	en in Part I.	23	e. Did tobac	co use cor	tribute to th	ne cause of death?	
Records,	The law requires that the death certifi tie has been signed by the attending rage 2 should be detached for use as		Congestive	, isc hem	ic C	ardi	omyopa	thy		1 🗌 Yes	2 No	3 🗌 Prob	ably 4 Unknown	
Ö	w requires been si	lete		/					24	a. Was an	24h	Were auto	psy findings available	-
Re	The lav	Completed								autopsy performed		pnor to cor death?	npletion of cause of	
Vita		e C	25. Was case referred to medical	1				00 DI		Yes 2	No	1 🗆 Yes	2□ No	
	Attanding Physician: r death. sctor: After this certification in the funeral director, it	O B	examiner?	Hospital:	tiont 2 🗆 E	R/Outpatient	3□ DOA Othe		of Death Chec		0.570			1
Division of	Phy or this oral o	\vdash	27. Manner of Death	28a. Date of In	jury	28b. Time of	3 DOA 28c. Injury	4 🗀 190	rsing Home 5	scribe how			/)	-
0	th. : After s funer	ertification;	1 → Matural 5 ☐ Pending 2 ☐ Accident investiga	(Month, E	Day Year)	Injury	M 1 🗆	í? ∕es 2∐1			, ,			1
<u> S</u>	or Attanc after death Diractor: in by the	iffice	3 ☐ Suicide 6 ☐ Could no	ad 286. Place of I	njury - At hor	ne, farm, stre	et, factory, office		28f. L.oc	ation (Stree	t and Num	ber or Rura	I Route Number,	-
á		Sert	4 Homicide determine	building,	etc. (<i>Specity</i>)				City	or Town, S	itate)			
	To the Hospital of within 24 hours at To the Funeral D completely filled in	aic	29a. Certifier 1 Certifying	Physician: To the bes	st of my know	rledge, death	occurred at the tim	e, date and	d place, and due	to the caus	e(s) and m	anner as st	ated.	-
	n 24 he Ft	edicai	(Check only 2 Medical Ex	aminer: On the basis and manner s	or examination	on and/or inv	estigation, in my op	inion, deat	h occurred at the	e time, date	and place,	and due to	the cause(s)	
	withi To th	Ž	29b. Signature and title of certifier	Λ Λn			29c. License	number		29d.	Date signe	ed (Month, i	Day, Year)	-
			Moning	- (100 a	001	110	00	1178	6	AP	RIL.	19,	2005	
1	~	1	30. Name and address of person wh	no completed cause of	ath (Il-m	23a) (Type, F	Print)					1		
_\	0		Laurence R	Gallager) /	716 Ma	iden	Choice	Lane	B	airo.	Md 21228	9
	Sta	tė	31. Date filed (Month, Day, Year)		trar's Signatu	11.0	A M	,			-/-			4
	Registr	ar i	ADD	e u bunt	Flore W.	· K	(Special)	,						

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H			giene neg. No. 0 0 5	13412
	Physici /Medio Examin	al	Dohn A. 4a. Facility Name (If not institution,	Shaw		4b. City, Town, or	Location of Dea	2. Date of Dea Month April	Day Year 18 2005	7:30 P ^M
	Funeral	ier	5229 Even Sta	r Place	ge (In yrs. last birthday,	Columbi	а	S. 8. Date of Birth	Howard 9. Bi	nthplace (State or Foreign ountry)
	Director Mode	_	Usual Residence of Decedent 10a. State 10b. County		78 Yrs.	ocation		Sept. 1	, 1926 Mic	10d. Inside City Limits
	with the Ma 3s or 28e-f	I Director	Maryland Howar 10e. Street and Number 5229 Even Star		Columb	10f. Zip Code 2104	/1	1	U.S.A.	1 ☐ Yes 2 No
20	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If itam 27 is marked other than "natural", or Itame 23a or 28e-f show injury or other traumetic evant, the Mudical Exam art must be maffiled at high or 9a.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	No Will II	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Whi	
70-6171	within 72 hound.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	16a. Dece (Give 5+)	dent's Usual Occupa kind of work done of DO NOT use retired	during most of w		16b. Kind of Business	s/Industry
ומוות ל	should be filed within nd Mental Hygiene. I markad othar than umetic evant, the Mar	To Be Co	17. Father's Name (First, Middle, La Frederick John	,	Admi	nistrator	18. Mother's Na	ame (First, Middle,		urity Adm.
C, Mai	1 and 2 sho Health and I Iam 27 Is me		19a. Informant's Name/Relationship Dorothy Shaw 20a. Method of Disposition	(Type, Print) (Wife)	5229	ng Address (Street a Even Star osition (Name of matory or other place	Place		r, City or Town, State, a, Marylan 20c. Location - City or	d 21044
	permit. Pages 1 a Department of Hes Important: If itam any Injury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lie	cify)	Columbia		Pk. 4-2		Columbia,	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Luet (d the death. Do not en	555 TW1n ter the mode of dying	Knolls 1	Road Col	umbia. Mar est.	yland 21045 Approximate Interval Between Onset and Death
,0070	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):					
O. BOX O	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	hyslcian/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetel death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ords, r.	w requires that t been signed by should be detac	by P	Part II. Other significant condition	s contributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribute to	o the cause of death?
VIIai nec	sician: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				OC Place of Do		ry prior to ned? death? 2 XNo 1 ☐ Yes	utopsy findings available completion of cause of 2 No
SIOI OI AI	ding Phya I. After this funeral di	ertification; To Bo	examiner? 1 Yes No 27. Manner of Death Astural 5 Pending investiga 3 Suicide 6 Could no	28a. Date of Inju (Month, Da	ıy Yea <i>r)</i> Injury	f 28c. Injury Work M 1 \(\sum Y	or: 4□ Nursing	28d. Describe ho	ence 6 □Other (Spe ow injury occurred	
2	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	4 Homicide determin	building, e	jury - At home, farm, stite. (Specify) of my knowledge, deat	n occurred at the tim	e, date and plac	City or Town	ausa(s) and manner a	e stated
	To the Ho within 24 h To the Ful completely	Medical	(Check only 2 Medical Expone) 29b. Signature and title of certifier	eminer: On the basis of and manner st	of examination and/or in	vestigation, in my op	inion, death occ	urred at the time, d	ate and place, and due	e to the cause(s)
11	21/		30. Name and address of person with				1139	2.1	pre 19	m, 05
Ĭ	Sta Registr		Clement B. H	32. Registr	ar's Signature			twy Colum	nbia, MD 2	1044
DHI	MH 17 Rev 1/20	001	APR	2 0 2005	action 10.	and the same				

ORIGINAL

December 1, Now and Price of Control December 1, Now				For State Registrar	State of Marylar	-	artment rtificate			and Me		giene Reg. No.	2000	131	13
POWER TO A STATE OF S		Physici	an						-	2.	Month	Day			
PURITURE CARE-HOMEWOOD Puriture Care-Homewood Puritu		/Medic	al				4h City T	Fown or	Location o	of Death	4/14				0 a™
The control of the co		Examin											-		
10.5 State 10.5 Colored 10.5 C				- 11	7 M 2005					24 Hrs. 8 Min. 6	Date of Birt (Month, Day /10/1	b, Year)	9. Bi	ountry)	o <i>r Foreig</i> n
Gabriel Garcia Gabriel Garcia		pu .			10c. Ci	tv. Town or Lo	ocation							10d. Inside	City Limits
Gabriel Garcia Gabriel Garcia		Maryla f sho	ō												•
Gabriel Garcia Gabriel Garcia		h the	lrec		Dai	CIMOI	_	Code				10g. Cit	izen of What C	ountry?	
Gabriel Garcia Gabriel Garcia		ath wit	a D	2839 Clifton A											
Gabriel Garcia Gabriel Garcia		items Items	nue		Armed Forces?	J.S. 13.	Was Decede If Yes, speci	ent of Hi ify Cubai	spanic Ori n, Mexican	gin? (Specif n, Puerto Ric	y Yes or No- can, etc.)	-			
Gabriel Garcia Gabriel Garcia	920	urs af	by		If Yes, Give		1 ☐ Yes 🔀	∑ No	Specify:				Specify: B	lack	
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5	Physician: this cartific ral director,		examiner? 1 ☐ Yes 2 ☐		Hospital: 1 ☐ Inp	nationt 2	ER/Outpetien	t 3□ DOA				dence 6 □Oth	er (Specify)		
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Division	tal or Attending Programmers after death. In Director: After the director is the funeration by the funeration:	3	2 ☐ Accident 3 ☐ Suicide	investigation	1				☐Yes 2[
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	State Registrar		31. Date filed (Mon	th, Day, Year)	32. Reg	istrar's Signa	iture	1 dra	d's						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** TATLOR JEAN A:20PM 4PRIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKING BAYVIEW BALTI MORE HEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | No v 30, 1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 X F -36-5136 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avent, It is Medical Examiner: ust be notified at Director 1X Yes 2 □ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2236 Essex Street 21231 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene. Is marked other then "natural, or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emedio Marcantonio Martha Rettman ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra 2236 Essex Street Baltimore, Md 21231 por Disposition (Name of Disposition (Name of Date Date 20c. Location - City or Town, State Martha McCloud (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 4/20/05 4 □ Donation 5 □ Other (Specify) Baltimore, 21. Signature of Fune al Service Lictinsee 22. Name and Address of Facility Caczorowski Funeral Home, P.A. 1201 Dundalk Ave. Baltimore, Md 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BILATERAL TONTINE DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Box 68760, nding physician eq Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HEMODIALYSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No CORONARY HRTERY has page 2 HYPERTENSION certificate PULMONARY Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after I 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Wedical (Check only one) and manner stated. the 29b. Signature and title of certified 29c. License number KES - 000 LDEEPA MENON, MD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 BAYVIEW MEDICAL LASTERN MENON, CENTER 31. Date filed (Month, Day, Year) 2. Registrar's Signature APR 2 0 2005 Registrar

		•		epartment of Health and Certificate of Death	Mental Hygiene	5 13416
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Ye	3. Time of Death
В	Physicia /Medic		Alice Rose Upton		April 18, 2005	5:10 P. M
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		
			Sunrise Assisted Living	Severna Park		rundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 M 2 T 90 Y	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 30, 1914 Ma	Birthplece (Stete or Foreign Country) ryland
	pu s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
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	the the 28a-	rect	Maryland Anne Arundel G. 10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
	3a or	Funeral Directo	208 Oak Lane S.W.	21061	United Sta	ites
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (5) If Yes, specify Cuban, Mexican, Puer		American Indian, White, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show fa Madical Exer illus mast be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 12X No If Yes, Give 3 12X Widowed 4 Divorced Year or Dates:	1 ☐ Yes XX No Specify:	Specify:	White
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جَ	2 should and Me 1s mark raumatid	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or R	ural Route Number, City or Town, Sta	
	and 2 saith ar		VALUE OF THE PROPERTY OF THE P	O A Generals Hwy.		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is merked other than "natural", or items 23a or 28a-1 show any riqury or other traumatic event, the Modical Examiner most be notified at ance.		1 ☑ Barial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of commatory or other place) Hill Cemetery	1 ^{Dat} 22, 20c. Location - Cit 2005 Brooklyn H	
Balti	permit. Departm Importa any inju		21. Signature of Fune al Servi, e Licensee	Kirkley-Ruddick Fu		21061
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- B	The ate h page	Com	, 0			ath?] Yes 2□ No
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of \	Physician: this certific ral director,	2			Home 5 Residence 6 Other 28d. Describe how injury occurred	
on (Jing After fune	tlon	1 Natural 5 □ Pending (Month, Day Year) In	ime of jury 28c. Injury at Work? M 1 Yes 2 No	Edd. Doddingo How Injury adda.	7
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Certification:	Accident Suicide	m, street, factory, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,
0	spital o ours aff seral Di filled ir		29a. Certifier 1X Certifying Physician: To the best of my knowledge.	death occurred at the time, date and place	ee, and due to the cause(s) and mann	er as stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	Vor investigation, in my opinion, death occ	curred at the time, date and place, and	d due to the cause(s)
	To t To t	Σ	29b. Signature and the of certifier	29c. License number DY19	29d. Date signed (9.05
1	10		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	#204	21108
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	H. Scarles	, menson	C , \//
9.1	Regist	rar	APR Z U ZUPO DESEUSA	of a grant of		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month UUJ 3. Time of Death Day Physician Mary Ε. Utlev April 2005 11 10:53 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 950 Summer Hill Circle Gambrills Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Abouths Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Yrs Director 236-38-9391 77 March 6, 1928 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State show 10h. County 10c. City, Town or Location 10d. Inside City Limits avant, the Medical Examiner must be notified at Director 1 □Yes 2√√No MD Anne Arundel Gambrills 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 950 Summer Hill Circle 21054 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **2XX**No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. ð Specify: 3√XWidowed 4 □ Divorced White 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental Heant: If item 27 is marked off jury or other traumatic avan Be H.M. Lilly Stella Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April May (Daughter) 950 Summer Hill Circle, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Epiphany Episcopal 4/16/2005 Odenton, MD 21. Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardia disease or condition resulting in death) /Medical Due to ()r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy lor in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? filled in by the funeral director, page 2: autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 210010 Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify)

Injury at 28d. escribe how injury occurred 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? after death. Division or Attanding Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To tha 29d. Date signed (Month, Day, Year) 0 DT3462 4/13/05 MD

Registrar

State

Herry It

1895 OH KWOOD

32. Registrar's Signature

Road Glen Burnie,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jude Munerca

31. Date filed (Month, Day, Year)

			State of Maryland / Dep	artment of Health and Martificate of Death	•	ne	13418
	Physici	an	1. Decedent's Name (First, Middle, Last) Rose Marie Valenti		2. Date of Death	Day 2005 Year	3. Time of Death 1:10 A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death	April 19	4c. County of Death Baltimore	
	Funeral Director	Г	5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday, 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 5,	9. Birthpl 2017 Ne	ace (State or Foreign try) W York
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Baltimore Lutherv			10	0d. Inside City Limits 1 ☐ Yes 2 No
	with the	Funeral Director	10e. Street and Number	10f. Zip Code		Citizen of What Coun	try?
	Jeath The 234	eral	307 Valley Court Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21093 Was Decedent of Hispanic Origin? (Spe		SA 14. Race - America	an Indian.
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heatith and Member Hygienes Hens 23a or 28e-1 show other treumstic event, the Medical Examination to differ a colifical	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, e	
215-0	hin 72 ho	Completed	15. Decedent's Education (Specify onfy highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	dent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b	Kind of Business/Ind	lustry
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/land	uld be fi Mental H arked ott	To Be	17. Father's Name (<i>First, Middle, Last)</i> Settimio Rosati	Julia	Figliulo	den Sumame)	
Baltimore. Marvland 21215-0036	ind 2 sho alth and 27 is ma or treuma		19a. Informant's Name/Relationship (Type, Print) Thomas Valenti /son 19b. Maili	ing Address <i>(Street and Number or Rura</i> 7 Valley Court Roa	d, Luther	ty or Town, State, Zip Ville, MD	^{Code)} 21093
ore	0 0			matory or other place)		Location - City or Tov	
THE THE	permit. Pages Department of Importent: if II any injury or o			Svc. Corp. 04/20		Towson, M	
ä	Der Imp			050 York Road, Tow	son, Mary	land 21204	
1:10 A.M. 8760.	The law requires that the death certificate be executed by the lass been signed by the attending physician and be detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	rolle Cerelle	:433	Diese	Onset and Death
. 2005 .O. Box 6	at the death certific by the attending platached for use as t	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
, 19, ds. P	ires that signed b		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		o use contribute to the	* -
APRIL Records	aw require as been si 2 should t	Completed by	Masouret Machen		24a. Was an	24b. Were autop	sy findings available
		_	1/ sm safet		autopsy performed 1 Yes 2	death?	pletion of cause of
NTI Vita	vysicien: The nis certificate h i director, page	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatier	26. Place of Death		6 ☐Other (Specify)	
VALENTI	Attending Physiclen: r death. sctor: After this certific. by the funeral director.	atlon: T	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how in		
ROSE VAI	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural ate)	Route Number,
,	ne Hospital or 124 hours afte te Funerel Dir Hetely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause at the time, date a	(s) and manner as sta and place, and due to	ted. the cause(s)
	To the within 2 To the complet	M	29b. Signature applittle of certifier	29c. License number	Z 29d. [Date signed (Month, D	ay, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type,	,		/ /	
	Sta	te	EDDIE NAKHUDA, M.D. 2300 DULANEY VA 31. Date filed (Month, Day, Year) 32. Registrar's Signature	LLEY ROAD TIMONIU	M, MD 210	93	
	Registr		APR 2 0 200	1 1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥬 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Dev Year **Physician** Kosie Wilson = 4 05 4.00 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Home Columbia NUVSIF Howard Hours Min. 8. Date of Birth (Month, Day, If Under 1 Year Months Days 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months 1□ M 2K F 212.52.3319 Usuel Residence of Decedent Yrs. Director deeth with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 M No COLUMBIA Funeral Director MD HOWARD or 28a-f 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? ROAD 5650 OAKLAND MIUS 21045 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status permit. Pages 1 end 2 should be filed within 72 hours efter Depertment of Health end Mentel Hygiene. If flem 27 is marked other than "neturel; or fle 1 ☐ Yes 2 **K** If Yes, Give Year or Dates: 1 Never Married 2 Married 2 K No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: BLACK Be Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 7 14 GRADE NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) AUGUSTUS JONES RACHAEL M. DORSEY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANCY A. BRIGHT 5813 HARPER FARM RD., COLUMBIA , MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 BBurial 2 ☐ Cremation 3 ☐ Removal from State injury or 04.22.05 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) BALTO. NATU 21. Sign we of Fune all ervice Licen ee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO, NATL PIKE, BALTO, MO 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or h dilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Sepsis Examiner Due to (or as a consequence of): accident-Physician/Medical Examiner Cardio viscular or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Chronic Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? hes 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No this certificete 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To 1 Yes 2 No To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number MD) Duo5370 9 lain 30. Name-and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Galland Bruie 14300 CHHW LA 32. Registrer's Signature 31. Date filed (Month, Day, Yeer) State

DHMH 16 Rev 6/95

Registrar

APR 2 0 2005

Hason E. Webb 05-2510 AKG

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			Decedent's Name (First, Middle, La	st)			timodio or z		2. Date of Dea	Reg. No	V 13	3. Time of Death
	Physici		Hason	E).		Webb		April 1	LO. 200	Year 5	8:55 A M
	/Medi Examir		4a. Facility Name (If not institution, given	e street and number)			4b. City, Town, or	Location of Death	-	4c. Count		0.55 A
1	LXuiiii		13132 Pickering	Drive			Germa	ntown		Montg	omerv	
	Funeral		5. Social Security Number 6. S	iex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day			place (State or Foreign
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	pu >		Usual Residence of Decedent 10a. State 10b. County		100 City	Taura sala						
	anyla shov	-		NA	Toc. City,	Town or Lo	Newark				1	Od. Inside City Limits
	Ba-f	ecto		INA								X□Yes 2□No
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	s 23s	rai	121 Smith Stree			1.0						
	item Item	n n	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Ha	ce · Americ ck, White,	
36	Ir, or		1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X 1 If Yes, Give Year or Dates:	40		1 ☐ Yes 2 X ☐ No	Specify:		Specif	у: B1	ack
21215-0036	72 hours after natural', or ite ilcul Exernine	Completed by	15. Decedent's E	ducation		16a. Dece	dent's Usual Occupa	ition		16b. Kind of B	usiness/In	dustry
215	nin 7.	pie	(Specify only highest grant Elementary/Secondary (0-12)	ide completed) College (1-4or 5	54)	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of wor	king			,
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<u> a</u>	uld b Venta rrked	70	Edward			Jones		Samon	e		We	ebb
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. It am 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Mardical Examinal must be notified at		19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a	nd Number or Ru	rai Route Numbe	r, City or Town	, State, Zip	Code)
	and ealth m 27		Samone Webb	Mother			Smith Str	eet, New	17740	r. (07106	
ore	of H of H if ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ice of Dispo netery, crer	sition (Name of matory or other place	9)	Date	20c. Location	-	
Ë	Pag ment tant:		`4 ☐ Donation 5 ☐ Other (Special		Ev	ergre	en Cemete	ry 4-2	23-05	Hills	side,	N.J.
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 It any injury or other tra once.		21. Signature of Funeral Service Lice	1500			Name and Addres March F.H			more, i E. Nort		21202 e.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not ent	er the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. d	411		1.11. 1	,				Onset and Death
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	certifi ding se as		IF FEMALE:	23c. If yes, outcome	of pregnance	ev				004.0-		
Box	atter atter I for u	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)				ite of delive onth	Day Year
0	the c y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown								
<u>a.</u>	s that ned b	by PI	Part II. Other significant conditions	ontributing to death b	ut not result	ing in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use cont	tribute to th	e cause of death?
Records,	w requires that s been signed t should be deta	ed b							1 □ Y	es 2 🗆 No	3 🗆 Prob	ably 4 Minknown
တ္တ	s bee	Completed							24a. Was a	n 24b.	Were autor	osy findings available
Ä	The law te has l	E							autops perform 1 X Yes			npletion of cause of 2[] No
Vital		a	25. Was case referred to medical					26. Place of Dea	th (Check only or		es	20 110
f V	Physician: r this certific ral director,	To B	examiner? 1 X Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 El	R/Outpatien	t 3 DOA Othe	r.	ome 5 Reside		er (Specify	at scene
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Sio	Attending ir death. ector: After by the fune	ati	2 Accident investigatio	Titolog		2115	M 1 1 Y	es 2 No	puljed	Plup		
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	urs al					treby	truchor	se	Germanter	m, Many	led	ckning over,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Pt Medical Examone)	ysician: To the best on the basis of and manner sta	examinatio	edge, death in and/or inv	n occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the corred at the time, d	ause(s) and ma ate and place,	inner as sta and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	. 2/			29c. License		2	9d. Date signe		
)	1	/	7 herbe	11 X49	5 -c.	2	OCI	YLC.		Apri	1 11,	2005
	V		30. Name and address of person who	completed cause of	eath (Item 2	За) (Туре,						
,	1		THE POURE MIL	Ling		-	III Pe	enn Stree	et Balt:	imore,	Maryl	and 21201
	Sta Registr	1 10	APR 2 0 20	05 Registra	ar's Signatu	Age.	after .					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16, 2005 **Physician** Carol Ann Saccocia Wood 0603 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 23, 1937 Montgomery 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□ F 033-28-8341 Director Massachusetts Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits or 28a-f show treumetic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8310 Greenwood Avenue 20912 or Items 23e United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Š 3 ₩idowed 4 Divorced naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene em 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Department of 4 Civil Servant Health and Human Sys. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John B. Saccocia Esther Marion Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tret once. Kevin James Wood / 8310 Greenwood Ave., Takoma Park, MD Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/19/05 Beltsville, MD 21. Signature of Funeral Se Rapp Funeral and Cremation Services Stephent Johnman 933 Gist Avenue Silver Spring, MD M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Tue to (or as a consequence of) Examiner Sequentially list nor officer if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a conseque attending physician a for use as the burial-Box 68760. Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death Month Day 5 Other (specify) P.O. | the 9☐ Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but no resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXVo Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🌠 Natural 2 🔲 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check one) Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango 7610 Carroll Ave Takoma Park MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature Genera & Specie Registrar

ORIGINAL

			1 - For State Registrar	State of Mary			Health and	Mental Hy	giene Reg. No. 005	13422
	Physic	ian	1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea		3. Time of Death
	/Med		GORDON	THOMA	S	WARD		April	Day Year 15, 2005	
	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	ath	4c. County of De	
			218 South Somerset	Avenue			Crisfield	1	Son	merset
	Funeral Director		5. Social Security Number 6. Sec. 215–20–2280	7. Age (In XM 2□ F	yrs. last birthday, 79 Yrs.	If Under 1 Yea Months Day		n. (Month, Day		irthplace (State or Foreigi Country) Maryland
	land ow		10a. State 10b. County	100	City, Town or L	ocation				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I than "natural; or Items 23a or 28a-f show item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, If a Medical Examiner must be rediffied at	Funeral Director	Maryland Somer	set		Cr 10f. Zip Code	isfield		10- 02	1 ∑Yes 2 ☐ No
	with so	0	177						10g. Citizen of What C	ountry?
	leath	era	218 South Somerse	12. Was Decedent Ever	in II S 12		21817	Secretary Version N	USA	
	72 hours after death w "natural", or Items 23a	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, specify Cu	ban, Mexican, Pue	Specify Yes or No- nto Rican, etc.)	14. Race - Am Black, Wh	
ž	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	1974	1 ☐ Yes 2 🂢 No	Specify:		Specify: Wh	ite
Ş	2 hou	Completed	15. Decedent's Ed			dent's Usual Occu	ination		16b. Kind of Business	Andreas
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21215-0036	filed within Hygiene. Ither than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	1		ates Army		Governmen	
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Maryland	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Ada V. Ward (Wife							
	item 27	1 3	20a. Method of Disposition					-	risfield,	
ਠੁ	90 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	iomovan nomi otato	b. Place of Dispo cemetery, crei				20c. Location - City or	
	tmer tant tant		' 4 Donation 5 Dother (Specify)	,0	unnyridge	Memorial F	ark Apr.	. 18,2005	Crisfield	d, Maryland
Baltimore,	permit. Pag Department Important: I any injury o			Odshaw-Pruitt	3(06 W. Ma	in Street	neral Hon	614 MD 2	1917
			23a. Part 1. Enter the disease, or comp- shock, or heart failure. List only o	ications that caused the c	death. Do not ent	er the mode of dy	ng, such as cardia	ic or respiratory arre	est,	Approximate
	Physician		Immediate Cause (Final disease or condition	no ex cus	+ off	Ima	CMARA			Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a con	sequence of):	01197	amen			32 mo
	Examiner				004001100 017.					
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	nsit	Examiner	Saque than list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, ,					
p.	al-tra	xa	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
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000	cate phys	edic		1						
X	death certificate be executed e attending physician and id for use as the burial-transit	/Me	IF FEMALE:	3c. If yes, outcome of pre	anancy.					
ממ	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnanc	у		23d. Date of del Month	livery Day Year
	the di	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	ordeath 5∟	Other (specify) _			, , , , , , , , , , , , , , , , , , ,	Day
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DIVISION OF VITAL NECONDS,	w requires that been signed I should be det	ted by	Part II. Other significant conditions cor	ntributing to death but not	resulting in the ur	derlying cause gr	ven in Part I.		acco use contribute to s 2 □ No 3 □ Pr	
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Ž	ine ha	Completed						autopsy	ried? prior to death?	completion of cause of
3	certificate rector, pag	O .	25. Was case referred to medical							2 🗆 No
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5		1: To	27. Manner of Death		2 ER/Outpatient 28b. Time of	3□ DOA 28c. Inju	4 Nursing F		nce 6 Other (Spec	cify)
5	After After funer	tlor	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Injury	Wo	k?	28d. Describe how	w injury occurred	
2	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Disco of Injury	A b		Yes 2 □No			
2	after Direction by	riti	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t nome, farm, stre ecify)	et, factory, office		28f. Location (Street) City or Town,	eet and Number or Ru State)	Iral Route Number,
-	urs a									
	To the rospital or Attending Frican 24 house safer death. To the Funeral Directors After the Completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 ■ Medical Examin	sician: To the best of my liner: On the basis of exam and manner stated.	cnowledge, death ination and/or inv	occurred at the tile estigation, in my o	me date and place pinion, death occu	and due to the cal arred at the time, da	ise(s) and manner as te and place, and due	to the cause(s)
1	withi Comi	Σ	29b. Signature and title of certifier	\		29c. Licens	e number	29	d. Date signed (Month	n, Day, Year)
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6	7		30 Name and advance of a second	moleted course of death (tom 20=1 (T		050/		7/10/05	
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el e	-C+		31. Date filed (Month, Day, Year)	Registrar's Sig	nature	MANUED IN	V)1 3	M VIS BUN	W (III)	11801
	Sta Registr		APR 2 0 2005	Element S	mature Span	LI				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** Michae 500 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. if Under 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In yrs. last birthday **Funeral** Days Months Hours Min. 1XM 2□ F 218 46-62-78 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, it e Medical Examiner a ust be notified at Director 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NON , or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race -American Indian Black, White, etc. filed within 72 hours after 2 Married 1 Never Married 1 ☐ Yes 2 ☐ No Blac Specify: 4 Divorced ģ 3 Widowed 'neturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Importent: If item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) ear a he 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) arvland Be 1 and 2 should be 200 ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Areet and Number or Rural Route Number, City or Town, State, Zip Code) doughter 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State Pages . 1 Burial 2 Cremation 3 Removal from State injury or 5 Other (Specify) 4 Dopation remalors . Cign, ure of Funeral Service Licenses 22. Name and Address of Fallity Balto 21229 md. m. Wallow Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-fransit Due to (or as a consequence of): Box 68760 Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an page 2 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, certificate has director. P this Certification: After death. Director: in by the after within 24 hours a To the Funerel C Medical

1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 🗌 Suicide

4 | Homicide

1 Inpatient 28a. Date of Injury (Month, Day Year) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License numbe

30.)Name and add

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State Registrar

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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	298	a. Certifier (Check only 2 one)	Certifyin	g Physicia Exeminer:	On the bas	is of examin	nowledge, de nation and/or	ath occurred investigation	at the time n, in my opi	e, date an inion, dea	id place, a th occurre	and due to the ad at the time	cause(s) a , date and p	ind manne place, and	r as state due to th	ed. 1e cause(s)
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	30.	Name and addre	ss of person	who comp	eted cause	of death (Ite	em 23a) (Typ	e, Print)	11 -				_				
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DHMH 17 Rev 1/200	,						ORIGIN	IAL									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 April **Physician** Edward A. Wegerski 17 8:30a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct | 27, 1920 827 S. Montford Avenue ⁵ 2 1 7 - 1 4 - 602 1 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 1 M 2 □ F Maryland 84 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits or than "natural, or iteme 23s or 28s-f shov The Medical Examinational be notified at Directo 1 ¥Yes 2 □ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 827 S. Montford Avenue 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 19 12 -If Yes, Give Year or Dates: 19 16 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. College (1-4or 5+) N/a Elementary/Secondary (0-12) 8 Forklift Operator American Can Co. marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H fitem 27 is marked ott Be Mary Olzacka Hipolit Wegerski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 S. 49th Street Baltimore, MD 21224 19a. Informant's Name/Relationship (Type, Print) Stanley Wegerski/ Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 ment of H ant: If ite 20c. Location - City or Town, State 1 ☐ Buriaf 2 MCremation 3 ☐ Removal from State injury or permit. Page Department of Importent: If eny injury or Bayview Crematory 4-19-2005 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Ligensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Finaf PROSTATE CARGNOMA Physician MEDASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 Other (specify) o the The law requires that the <u>م</u> signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? page certificate Division of Vital 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) P 1 ☐ Yes 2 ☐ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After To the Hospitel or Attending 1 Afatural 5 Pending To the most after death.

Within 24 hours after death.

To the Funerel Director: Aft 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DU1034 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) PAUL PLACE. 301 BARTMUNE W 57. 2. Registrar's Signature State Registrar

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Fune	ral		. Social Security Number 6. Sex	7. Age (In yrs. i	last birthday)	If Under 1 Year Months Days	If Unde	or 24 Hrs. 8. Min.	Date of Bir (Month, Da	ıy, Year,	Co	hplace (State or Fo	oreign
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Williams **Physician** 1541 Michele APRIL 2005 ila a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore CENTER MEDILAL 5. Social Security Number B. Date of Birth (Month, Day, Year) APAI 15, 2005 If Under 1 Year If Under 24 Hrs. 8
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 K F MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or iteme 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GREGORY Williams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FATHER BRIS RO 561 BAHEMB GREGORY WILLIAM 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/19/2005 Woodlawn, Maryland Woodlawn Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc.
736 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prematurity Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs [Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed nding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Ιō in the past 12 months? 5 Other (specify) should be detached APRIL 15,2005 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident hours after deat 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D00 894 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN Y. Perkins 5400 040 COURT Randallstown MD 31. Date filed (Month, Day, 32. Registrar Signature State 9 2005 Registrar

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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licen.	300		Ec	iwara	ds age	el Fu	heral	Direc	tion	, Inc.		
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Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	4 Homicide determined	28e. Place of in building, et	jury - At h tc. <i>(Speci</i> i	ome, farm, st fy)	reet, factor	y, office		2	City or Tox			Hurai Houle	Number,
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	ν		30. Name and address of person who	14 D											
			Barbara Kalazny, 31. Date filed (Month, Day, Year)	M.D.,			se Ro	oad,	Rock	ville	, MD 20	0852			
	St Regist	ate rar		005			ander								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1:40 A M Albert E. Lena 2005 April 8, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dennett Road Manor Nursing Home 0akland Garrett If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours 1 ☐ M 2 ☑ F 220-30-8112 79 Director April 8,1926 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 472 Gank Road 21550 238 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 'natural', or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2₺ No Specify: ⋧ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 6th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked Edith Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar important: If item 27 is any injury or othar treu once. Ronald Stewart/Son 170 Tannery Road, Oakland, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/11/2005 Zion Cemetery Swanton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 32 S. Second St. Stewart Funeral Home Oakland, Md. 21550 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours Prieumonia /Medical Due to (or as a consequence of): Examiner COPD years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (because of a jusy that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical as the the attending phed for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No page 2 certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🛣 No မှ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 XNatural 5 Pending investigation within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) certifie 29b. Signature and title of 4/8/2005 D15333 30. Name and address of terson who completed cause of death (Item 23a) (Type, Print) 311 N. Fourth St., Oakland, Md. 21550 Thomas Johnson M.D. 31. Date filed (Month: Day, Year) 32. Registrar's Signature State 2005 Registrar

05 - 02187Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alexander Bekker State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mentch 27Day 2005Year 2110P. **Physician** Alexander Y. Bekker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death Examiner Norbeck Rd. @ Bradford Rd. Silver Spring
If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min Yrs. 020 - 72 - 174148 31, Russia **Director** Jan. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or Items 23a or 28a-1 show the Medical Examiner must be notified at 1∏Yes 2□No Funeral Director Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2810 Norbeck Road None 20906 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Scientist-Engineer Private permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Importent: If Item 27 is marked other ti
any injury or gather treumatic event. III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yurll Bekker Rosa Gekkel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andrey Y. Bekker - Brother 8608 Jones Mill Road, Chevy Chase, Md. 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Chessed Shel Emmes Washington, D. C. * 4 ☐ Donation 5 ☐ Other (Specify) 4-8-2005 21. Signature of Funeral Service Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INNRIES **Physician** MULTIPLE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and on the cause). Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a Was an page 2 certificate 2 No 1 XYes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Nother (Specify) (Scene) 1 X Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After OF CAR IMPACTING FIXED Injury DRIVER 1 Natural 5 Pending 1 🗌 Yes 2 No 8:338 OBJECT investigation 3/27/05 2 Accident

Attanding Physiclan:

filled in by the funeral within 24 hours after death. To the Funeral Director: A ö

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide NORBELL ADE BRADFORD RO, HO ROAD 29a. Certifier (Check only one)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) March 28, 2005 29c. License number **OCME**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUB10 MD ANA

111 Penn Street

Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 05



To the Fune completely fi

To the h

Medical

			T = State Registrer	tate of Maryland	d / Depa		lealth and N	lental Hy	_) E 121.	21
			Decedent's Name (First, Middle, Last)					2. Date of De	700	3. Time o	f Death
	Physici		REBECCA RACH	EL BARON				Month MARCH 3	1. 200°	Year	
	/Medi		4a. Facility Name (If not institution, give stre			4b. City. Town, or	Location of Death			y of Death	1
	Examir	ier	HOLY CROSS HOSPITAL			•	ER SPRING			GOMERY	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.				or Foreign
	Director		144-14-3787 ¹□M	²X ^F 80	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da AUG 19	1924	9. Birthplace (State of Country) NEW JERSEY	
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. City	Town or Lo	cation				10d. Inside C	ity Limits
	Aaryli F sho	ŏ	MARYLAND MONTGOMER		LVER S						2 □ No
	28a-	rect	10e. Street and Number	1 31	LVER L	10f. Zip Code			10g. Citizen of	What Country?	
	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-1 show he Wedical Examinar must be notified at	Funeral Director	11743 LOVEJOY STREET			2090	2		UNITED	STATES	
	death	nerg	11 Marital Status 12.	Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No	14. Ra	ce - American Indian,	
9	after or ite			1 ☐ Yes 2X No If Yes, Give		Yes 2XX No		nican, etc.)	Speci	ick, White, etc.	
9	ours ural',	d b	3 Widowed 4 Divorced	Year or Dates:						MHITI	E
5	"nati	lete	15. Decedent's Education (Specify only highest grade co		16a. Deced	lent's Usual Occup kind of work done o	ation during most of work ()	ring	16b. Kind of E	Business/Industry	
21215-0036	withis ene. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		URANTEUR	,		RESTA	URANT	
9	filed Hygi other		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,			
an	ould be Mental tarkad c	To Be	JACOB FRIEDM	AN			LILLIA	ΔN	GOLI	BERG	
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	r, City or Town	, State, Zip Code)	
	and 2 salth a n 27 is		LOUIS BARON, HUSBAND		11743	LOVEJOY	STREET, S	SILVER S	PRING,	MD 20902	
ore	of He of He fiten		20a. Method of Disposition 1 Burial		ace of Dispo metery, cren	sitio n (Name of natory or other plac	e)	Date	20c. Location	- City or Town, State	
ij	Pag ment www.		'4 □ Donation 5 □ Other (Specify)	KING	DAVI	D MEM. GI	N. APRIL	4, 200	5 FALI	S CHURCH,	VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show minipror other traumatic avent, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	/	DA	Name and Addres	s of Facility	MEMORIA	L CHAPE	ELS, INC.	
	0.0 E @ 0l		Jacy M.	free		70 ROCKV	ILLE PIKE	E, ROCKV	ILLE, M	ID 20852	
				ause on each line.	. Do not enti	er the mode of dyln	g, such as cardiac	or respiratory ar	rest,	Approximal Interval Bel Onset and	tween
¥.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CARDIAC ARRH		1					
	Examiner		ſ	Due to (or as a consequ MYOCARDIAL I		TON					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		LON					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c								
ó	te be executed ysician and te burial-transit	Еха	resulting in death) Last	Due to (or as a consequent	ence of):						
3760,	icate be executed physician and s the burial-transit	lcai	d								
k 68	The taw requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:					<u> </u>			
Вох	ath co	ian/	in the past 12 months?	If yes, outcome of pregnan 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3□	Ectopic pregnancy				ate of delivery onth Day	Year
	he de	ysic		4∐ Pregnant at time of de 9∐ Unknown	atn ɔ∟	Other (specify)					
P.0	that the by detail		Part II. Other significant conditions contrib	uting to death but not resul	ting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the cause of o	death?
Records,	quires n signe ald be	Completed by	HYPERTENSION					1 □ Y	es 2X No	3 Probably 4	Unknown
000	aw require s been si 2 should I	ojete						24a. Was	an 24b.	Were autopsy findings	available
Re	sician: The law certificate has b irector, page 2 s	omi						autop perfor 1 Yes	med?	prior to completion of death? 1 ☐ Yes 2 ☐ No	ause or
Vital		o ·	25. Was case referred to medical				26. Place of Deat		71		
of V	ding Physician: After this certifications of the director,	To B	examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2🛣 E	R/Outpatien	1 3□ DOA Othe	er: 4 🗆 Nursing Ho	me 5 Resid	lence 6 🗆 Oth	ner (Specify)	
O L	fter fter	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World		28d. Describe h	ow injury occur	red	
sio	Attending r death. actor: After by the fune	cati	2 Accident investigation				Yes 2 No	00/ 1 / 0		0.70.04	
Division	l or Attendated after death	ırtifi	4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		City or Tow		ber or Rural Route Num	iber,
	Hospital or Attendi 24 hours after death. Funeral Diractor; A stely filled in by the f	S C	29a. Certifier 1X Certifying Physicia	n: To the best of my know	vledge, death	occurred at the tim	ne date and place.	and due to the o	ause(s) and m	anner as stated.	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Diractor: completely filled in by the	Medical Certification:	(Check only 2 Medical Exeminer: one)	On the basis of examination and manner stated.	on and/or inv	estigation, in my or	pinion, death occur	red at the time, o	date and place,	and due to the cause(s	;)
	To the Within To the	Me	29b. Signature and title of certifier			29c. License	number	- 2	29d. Date signe	ed (Month, Day, Year)	
	1		I beltal	man, r	T. D.	D2	20367		APRIL 1	, 2005	
	4		30. Name and address of person who compl								
			JOEL KALMAN, M.D.,			, ROCKVI	LLE, MD	20850			
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 5 2005	32 Registrar's Signat	THE STATE OF	ules					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For Amend Item Registrar	1 per me G843	5-24-05 Cei	tas tificate of	Death	Reg	0 0 5	13432
	Physici	an	1. Decedent's Name (First, Middle,	,				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Richard Lee Ber					April 5,		03:33 A. ^M
	Examir	er	4a. Facility Name (If not institution, g				r Location of Death		4c. County of Deat	h
			Route 228 & Midd			Waldor			Charles	County
	Funeral Director		5. Social Security Number 216-23-9669 Usual Residence of Decedent	. Sex 7. Age (In 10 M 2 □ F 20	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Dec. 22,	1984 Mary	hplace (State or Foreign untry) / and
	and w		10a. State 10b. County	10c	: City, Town or Lo	cation				10d. Inside City Limits
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jical Examinat natal te notified at	Director	Maryland Charle	es	Waldort	1				1 ☐ Yes 2X No
	vith th	吉	10e. Street and Number			10f. Zip Code			g. Citizen of Whal Co	
	s 238	Funeral	10915 Moore Str			20603			United Sta	
	er de Itam	nu	11. Marital Status	12. Was Decedent Ever	in U.S. 13. \	Vas Decedent of F f Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
Baltimore, Maryland 21215-0036	72 hours aft "natural", or	þ	1 🛱 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 'Year or Dates:		Yes 2No	Specify:		Specify: Whi	te
7		Completed	15. Decedent's (Specify only highest of		16a. Deced (Give	lent's Usual Occup kind of work done	ation during most of workir d)	ng 16	6b. Kind of Business/	Industry
121	within ene. than "	g E	Elementary/Secondary (0-12)	College (1-4or 5+)	1					
2	llad v tygie thar t	ပိ	12 17. Father's Name (First, Middle, La	et)	Аррү	entice E	lectricia		<u>Electric</u>	
and	ntal H	Be	Richard Lee Ber				18. Mother's Name		,	
Ž	es 1 and 2 should be filad within of Health and Mental Hygiene. I flam 27 la markad othar than r othar traumatic event. It e M.	2	19a. Informant's Name/Relationship		405 14 15	1.(1)	Geraldine		J	
Ma	12 sl h an 7 la r traur								City or Town, State, Z	ip Code)
e,	1 and Healt am 2 thar		Ernest F. Dougla 20a. Method of Disposition		Db. Place of Dispo	Moore S	treet, Wa			Farma Chata
ō	or or		1 X Burial 2 ☐ Cremation 3	Removal from State	cemetery, cren	natory or other plac	ce)		c. Location - City or	
ij	parmit. Pag Department Important: I any injury o	1	`4 ☐ Donation 5 ☐ Other (Special	cify)	Resurrect	tion Ceme	etery 04-0	8-2005	Clinton, 1	Maryland
39	armii Depar Depar Depar Depar Depar		21. Signature of Funeral Service Lic	ensee M01391	22	Name and Addre	ss of Facility eral Home			
	40300		23a. Part1. Enter the disease, or co	re	P	.O. Box	156, Wald	orf, MD 2	20604-0156	
	Physician /Medical		23a. Par1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a con	a In	er the mode of dyin	ng, such as cardiac of	respiratory arres	t,	Approximate Interval Between Onset and Death
н	Examiner									
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	be executed sician and burial-transit	Examiner	that initiated events	c.						
o,	an ar rial-ti		resulting in death) Last	Due to (or as a con	sequence of):					
68760,	icate be physicia the bu	ca		d						
89	ntifica ng ph as th	Medical	IF FERMIS							
.O. Box	requiras that the death cardificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Q	that led by deta		Part II. Other significant conditions	contributing to death but not	resulting in the un	derlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds	sign sign d be	d by		-		, ,			2 □ No 3 □ Pro	
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of Vital Records,	e la has	ompleted						24a. Was an autopsy performe	d? prior to c	opsy findings available ompletion of cause of
ta		Ö .	25. Was case referred to medical				26. Place of Death	1	No 1 X Yes	2□ No
>		OB	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 C ER/Outpatient	3C DOA Oth			o e V iother (Con-	(fy) At scene
Q		F .	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun		8d. Describe how		for the section
Division	를 근 중 글	Certification;	1 □ Natural 5 □ Pending 2 Accident investigati	ion (Month, Day Year	For ligury		k? Yes 2 No C	we grand	in which	weight
/is	Attendant death	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - A	At home, farm, stre		2	Bf. Location (Stree	et and Number or Ryi	ral Route Number,
Ö	spital or At ours after o neral Dirac filled in by	ert	4 Homicide determine	building, etc. (Sp	(voolus		ille	City or Town, S	State) Rout	22821
	spits nours nera	alc	29a. Certifier 1☐ Certifying I	Physician: To the best of my	knowledge, death	Courred at the tin	ne, date and place, a	nd due to the caus	se(s) and manner as	stated
	e Ho a Fu letely	edical	(Check only one) Medical Ex	aminer: On the basis of exame and manner stated.	nination and/or inv	estigation, in my o	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To the Hospital or Attenwithin 24 hours after death To tha Funeral Diractor: completely filled in by the	Me	29b. Signature and title of certifier			29c. License	e number	29d	. Date signed (Month	, Day, Year)
) The	11 Y.		00	ME		April 5,	2005
0		-	30. Name and address of person wh	o completed cause of death (Mem 23a) (Type I	Print)				
	185		HEDRIFE Mike	40		,	nn Street	Baltime	ore, Maryl	and 21201
	Sta	te	31. Date filed (Month, Day, Year)		gnature				+ **** Y 1	21201
	Registr		APR 0 7	2005 Persua	1 D 19	barke				

			1 - For State of Maryland / Depa Cer	rtment of Health and M tificate of Death	lental Hygie	- 6 0115	13433
П	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		MARGARET TABOR BANNER		APR 1	2005	11:17 P M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			NATIONAL NAVAL MEDICAL CENTER	BETHESI		MONTGOMER	
	Funeral Director		5. Social Security Number 578 • 40 • 5578 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 16,	9. Birthp Cour 1920 Aldr	lace (State or Foreign htry) ich, AL
	/land		10a. State 10b. County 10c. City, Town or Loc	cation		1	Od. Inside City Limits
	Many First	ğ	DC Washin	gton			1 ☐ Yes 2 🔀 No
	r 28g	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	th wit	aiD	3700 Massachusetts Avenue, N.W.	20016		U.S.A.	
	dea	ner		Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	
9	or it	J.	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	Yes 2 No Specify:	rioan, etc.,	Black, White,	
Ö	urel',	d by	Aear of Dates:			Specify:	White
꺗	filed within 72 hours after death with the Maryland Hygiene ther then "naturel", or Iteme 23a or 28a-1 show ont, the Medical Exertirer must be notified at	Completed	15. Decedent's Education (Give (Give)	ent's Usual Decupation kind of work done during most of worki O NOT use retired)	ng 16b	. Kind of Business/Ind	dustry
7	withi ene. then	ш	College (1-4or 5+)	el Management Spec		NSA	
0	Hyg Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "naturel", or iteme 23a or 28a-f show eumatic event, it whe died Exertire irrust be notified a	To B	William Stewart Tabor	M	innie Jenn	nelle	
a	2 sh and ts m			Address (Street and Number or Rura	l Route Number, Cit	ty or Town, State, Zip	Code)
ď	l and lealth m 27 her ti		Linda Tully/ Daughter 8001 1	Piney Branch Rd. S			
2	Pages nent of hint: If ite		Labourial 2 Cremation 3 Chemoval from State	atory or other place)	3.0	. Location - City or To	
Ξ	rtmer rtent rtent			n Nat. Cem. May 1			
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic es once.		MAIM Dec 51	Name and Address of Facility Jos 130 Wisconsin Aver	rue NW WDO		Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Frrysician /Medical	i y	Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAS	T CANCER			Onset and Death
	Examiner		Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted J Insit	min	Cause (Disease or injury				
ĵ	exection and ital-tra	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
9/60	cate be executed obysician and the burial-transit	cai	d.				
õ	ing ph	Med	IF FEMALE:				
X R Q	eath certitic attending p	lan/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Live	Ectopic pregnancy		23d. Date of delive	
- -	the a	Physician/Med	1 ☐ Yes 2 ☑No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day Year
J.	that the dended by the set detached to		Part II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I	23a Did tohaco	o use contribute to th	a square of death?
ecords,	8 5 5	d by		activity oddso giron in rain.		2 No 3 □ Proba	
õ	> 2 2	Completed			24a. Was an		
r	0 5 0	d mc			autopsy performed?	prior to con	sy findings available apletion of cause of
		Ö	25. Was case referred to medical	OC Place of Death		No 1 ☐ Yes	2 🗆 No
5	0 77	0 8	examiner? 1 Yes 2 Xo Hospital: 1 Papatient 2 ER/Outpatient	26. Place of Death		6 ☐Other (Specify	
0	ding Phy h. After thi tuneral	T:U	27. Manner of Death 28a. Date of Injury 28b. Time of		8d. Describe how in		/
VISION	tendin Jeath. tor: Afi the tur	atio	2 Accident investigation	M 1 Yes 2 No			
Š	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
	Itel o						
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the tuner	edicai	29a. Certifier (Check only one) 1	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of sertifier	29c. License number	29d. D	Date signed (Month, E	
	8		Jan M. Ditt My	ME-88648 (FL)	1	Peril 6	2005
	(3)		30. Name and address of person who completed cause of death (Item 23a) Type, P DAVID M. BRETT-MAJOR LCDR MC US	rint) NATIONAL NAVAI SN BETHESDA MD 20		CENTER	
	Sta Registra		DAVID M. BRETT-MAJOR LCDR MC US 31. Date filed (Month, Day, Year) APR 0 7 2005	E E E E E E E E E E E E E E E E E E E	7007-3000		

		•	1 - For State Registrar		State of I	Maryland	-	artment <i>rtificate</i>			and M	lental Hy	giene Reg. No	711115	13434
	Divi-i		1. Decedent's Name (First, N	iddle, Last)								2. Date of De	aath Da	y Year	3. Time of Death
	Physici /Medic		Dorothy	Irene	Bell							April_		2005	10:50p M
	Examin		4a. Facility Name (If not instit	ution, give s	street and numb	er)		4b. City, To	own, or	Location of	of Death		40	. County of Death	
			Southern Mary					Clin		If I lade	0411			Prince G	
	Funeral		5. Social Security Number 577-44-5967	6. Sex	7. M 2 4 7.	Age (In yrs. la 70	ast birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Bit (Month, Da	ay, Year)	9. Birth	plece (State or Foreign intry)
	Director		Usual Residence of Deceden	t		70						Jan. 4	+, 19	935	DC
	yland		10a. State 10b. Co			10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mar st	tor	Maryland Pri	nce 0	George	Clin	ton								1X Yes 2 ☐ No
	or 28	Director	10e. Street and Number					10f. Zip C	Code				10g. Cit	izen of What Cou	intry?
	23a		9106 Pineview	Lane	:			20	0735	5			Uni	ed Stat	es
36	s 1 and 2 should be tiled within 72 hours aftar daath with the Maryland if health and Mental Hygiene. Itam 27 is marked othat than "natural", or Itams 23s or 28s-f show othat transmissions than the motified at othat transmissions of the motified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ※ Divo	Married	12. Was Decede Armed Force 1 ☐ Yes 2 I If Yes, Give	s? XNo	1	Was Deceder f Yes, specify 1 \(\text{Yes} \) 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White	, etc.
8	hour tural	ed b		dent's Edu	Year or Date	s:	16a Dece	dent's Usual	Occupa	tion			16h K	BLa	ack
15	in 72 in na	Completed	(Specify only h	ghest grade	e completed)		(Give	kind of work DO NOT use	done di retired)	uring mos	of worki	ng	100. K	ind of business/if	ndustry
212	f within piene. r than "	шо	Elementary/Secondary (0-10th	2)	College (1-4)	or 5+)		erk					Gov	vernment	
פַ	e tiled withing Hygiene. other there	Bec	17. Father's Name (First, Mid	dle, Last)		-				18. Mothe	r's Name	(First, Middle			
/lar	should be ind Mental markad o umatic eva	ToE	William Bow	den						Mar	ion	Bell			
Maryland 21215-0036	is 1 and 2 should be of Health and Mental itam 27 is marked other traumatic ev		19a. Informant's Name/Relat Linda Portis		oe, Print) ughter									nr Town, State, Zi Md. 20	
ore,	as 1 a of He of He ritam		20a. Method of Disposition	2 OD		20b. Pla	ace of Dispo	sition (Name	of er place)	D	ate	20c. L	ocation - City or T	own, State
Ĕ	Paga ment ant: It		1 ☐ Burial 2 🌠 Cremat `4 ☐ Donation 5 ☐ Othe		emoval from Sta	llo I		tan Cı			4-6-	-05	Alex	andria,	Virginia
Baltimore,	permit. Pagas 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Funeral Sen	rice License	ee ^	10/01	A 22	Name and 1exand 538 Ma	Address der arlb	S. Po	ope 1 Pike	Funeral Forest	Hon	nes .e.Md. 20	747
			23a. Part1. Enter the disease shock, or heart failure.	, or compli	cations that cause cause on each									c,iid. 2	Approximate Interval Between
	Physician	2 4	Immediate Cause (Final disease or condition	,,		BEA	in +	man		noul				-	Onset and Death
	/Medical		resulting in death)		Due to (or	as a consequ	ence of):	0 +	- 1	0		741	-1		
	Examiner		Sequentially list conditions.	ь	.=	Le	ft.	Porrell	al	Bra	M	Hemm	nhu	12	
	be sit	iner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Į	Due to (or	as a consequ	ence of):	~	1:+				(
	and and I-tran	Examine	that initiated events resulting in death) Last	0	Due to /or	as a conseque	follow	meu	Mu	2					
60,	cate be executed physician and the burial-transit				00010101	ao a oonooqo	01100 017.								
68760,	licate phys s the	edicai													
Box (death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outcor									23d. Date of deliv	erv
m	death a atte d for	Iciai	in the past 12 months?		4 Pregnant	2 Fetat at time of de		Ectopic preg Other (spec	gnancy cify)					Month	Day Year
o.	that the de ed by the detached	hys	9 Unknown		9 Unknow	1									
S, D		by P	Part If. Other significant con	ditions con	tributing to deat	n but not resul	lting in the ur	nderlying cau	ıse give	n in Part I.		23e. Did t	obacco u	ise contribute to t	he cause of death?
rd	w raquiras been sign should be	ted										101	Yes 2	⊠No 3 ☐ Prol	oably 4-⊡Unknown
ecords	aw is b	Completed										24a. Was		24b. Were auto	opsy findings available ompletion of cause of
E E	Tha ate h page	mo:											rmed? 2 No	death?	
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to me examiner?							26. Place	of Death	(Check only o	ne)		
	Physical this call dire	P	1 ☐ Yes 2 No	Н	ospital:		R/Outpatien			4 LINUI	rsing Hor	ne 5 🗆 Resi	dence	6 □Other (Specia	fy)
U C		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pe		28a. Date of I	njury Da <i>y</i> Yea <i>r)</i>	28b. Time of Injury		C. Injury Work	?		28d. Describe	how infu	y occurred	
Sic	tan leati lor: the	cat	3 ☐ Suicide 6 ☐ Co	estigation uld not be	00a Diago of	Inium. Alban		M		es 2 🗆 f		106 Lanation (Ctunet		-1 Davida Missahar
-	- e = -	Certification;	4 Homicide de	ermined	28e. Place of building,	etc. (Specify)	ne, rarm, stri	et, factory, c	οπισε		4	City or To		d Number or Rura)	ar Houte Number,
_	spital ours saral filled		29a, Certifier 1 Cert	fying Phys	sician: To the be	st of my know	vledge, death	occurred at	the time	date and	dinlace a	and due to the	cause(s)	and manner as s	tated
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	Medical	(Check only 2 Med one)	cal Examir	ner: On the basis and manner	of examination	on and/or inv	estigation, in	n my opi	inion, deat	h occurre	ed at the time,	date and	place, and due to	o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of ce	tifier	. 1	7 ~		29c. l	License	number			29d. Dat	e signed (Month,	Day, Year)
)			> Glem F	. 80	Genorbi	(m)		D	238	26				4/2/05	-
			11 0 -	1	n leted cause of	f death (Item	23a) (Type,		Λ	4				2	
			Glenn K E	geco	mbe mi	7770	o Old	Bra	muh	Ave	<u>C</u>	Inter	1 M	1y ZO	735
1	Sta	te	31. Date filed (Month, Day, Y APR 0 7	^{อสง]} 2กกร	Z. Regi	strar's Signati	Jre -								
	Registr	ar	Mrn V I	£003	July 1	*	14								

(F)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Rosa Lee Broddie March 31, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

Jan, 21, 1939

9. Birthplace (State or Foreign Country)

North Carolina 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 578-54-6318 66 Yre Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Forestville Maryland Prince George 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 2516 New Glen Avenue 20747 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.

Importent: if item 27 is marked other than "natural", or items 23a any jidury or other traumatic event, the Medical Exercity DIRE. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Gaylor Lena Sanders ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2516 New Glen Ave., Forestville, Md. 20747 David Broddie/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National April 7,2005 Suitland, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 070/085 23a. Park. Efter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) army Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate the first incerting Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No Hospitel or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death Check on one examiner' Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Many er of Death 1 Natural 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Descritiving Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D005 7503 Sur Clinton, Dwayne Thompson, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Surra LS 31. Date filed (Month, Day, Year Registrar's Signature State 7 2005 APR 0 Registrar

				partment of Health and Mertificate of Death	fental Hygie	711115 13636
95	n a an		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		William H. Britt, Jr.			26 2005 1:12 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1101011	4c. County of Death
			Prince George's Hospital	Cheverly		Prince George's
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Birthplace (State or Foreign
	Director		238–48–1878 74		Sep. 20,	1930 North Carolina
	yland		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mar Me-f st	tor	Maryland Prince George's	Capitol Heights		1 ∑ Yes 2 □ No
	ith the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath w	rai	7602 Walker Mill Drive	20743		United States
	er der Items	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	I. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by Funerai	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
Maryland 21215-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or items 23e or 28e-f show ha Medical Examinar must be rediffed at		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b	. Kind of Business/Industry
215	hin 7	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ing	,
2	od wit	Con	12th	Engineer		Private
nd	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	
yla	ould Men Parke	70	William Britt, Sr.			a Green
Mai	12 sh h and 7 is m treum			iling Address (Street and Number or Rura		
e,	1 and Healt em 2 ther		20a. Method of Disposition 20b. Place of Disp	2 Walker Mill Rd.,		Hgnts, MD 20743 Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumatic event. The Medical Examinar must be rediffed at ODE.		1 Burial 2 □ Cremation 3 □ Removal from State cemetery, cr	ematory or other place)		
Ħ	artme orten injur			Veterans Cem. 4/7 22. Name and Address of Facility C		Cheltenham, MD neral Home
B	permi Depa Impo any ir		John T. Steveral TIT	4001 Benning Rd.		
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shoot, or heart failure. List only one cause on each line.			Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition FATAL CARDIAC	ARRHYTHMIA		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	7 (0-0-0) 11111111111111111111111111111111111		
	Examiner		Sequentially list conditions, b			
	ed sit	ine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury			
	and al-trar	Examiner	that initiated events resulting in death) Last			
8760,	icate be executed physician and s the burial-transit	dicai E				
9	ificati g phy as the	edic	V			
Вох	leath certific attending p	M/ul	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	C Estado		23d. Date of delivery
ω.	deat	sicia	1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	that the de led by the a detached f	Physician/Me	9 Li Onknown			
S,	gne	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		to use contribute to the cause of death?
Records,	w requir been si should	Completed			1 LI Tes	2 No 3 Probably 4 XUnknown
3ec	has the	ldm	KENAL FAILURE		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of
			HYPERTENSION		1 ☐ Yes 2 🔀	
Viital	Physicien: r this certifica ral director, I	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie	Other	Check onlone	
Division of	Phys er this eral dii	1: 10	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 ☐ Residence 28d. Describe how in	6 ☐Other (Specify)
io	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Vis	I or Attending after death. Director: After in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number,
	rs aft al Dii	Cer	Suitality, Ge. (Openly)		Oily or rown, Sa	ato)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only check only check) 2 ☐ Madical Examinar: On the basis of examination and/or in the basis of e	th occurred at the time, date and place, and nvestigation, in my opinion, death occurrence	and due to the cause ed at the time, date a	o(s) and manner as stated.
	the thin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		
)	Z 3 Z 8		An arela & Anarch 112	D56643		Date signed (Month, Day, Year)
\	10		30. Name and address of person who completed cause of death (Item 23a) (Type		3	0-29-05
4	9			HOSPITAL DR	CHEVERLY	3-29-05 MD 20785
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature		-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Registra	ar	APR 0 7 2005			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Bloxom 2. Date of Death 3. Time of Death **Physician** Month 10:28 AM ames ward /Medical nor 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor anokin Princess Anne 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthptace (State or Foreign 220-12-0899 Days Hours Min. 1**∀**M 2□ F Director Yrs. Atlantic Usual Residence of Decedent hours after death with the Maryland 10a, State 10b. County items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Examinating be notified at Funeral Director Maryland Somerset Westover 1 ☐ Yes 2 ☑ No 10e. Street and Number (10f. Zip Code 10g. Citizen of What Country? ehobeth 31109 21871 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural', or 21215-0036 à 1 Yes 2 No Specify 3 ₩idowed 4 Divorced Black Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade

17. Father's Name (First, Middle, Last) Man Maintainance MAND Maryland Be 18. Mother's Name (First, Middle, Maiden Sumame) t ပ James MOXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zir Code) Md. 2187/ Bloxom 31109 John zhobeth - d. MANDY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place * 4 ☐ Donation 5 ☐ Other (Specify) 9 Salisbur 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility Ward athony t tampden ave rincess HAMMA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year signed by the a 5 Other (specify) 9 Unknown of Vital Records, 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 has autopsy performed? 1☐ Yes 2 No ours after death.

erel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 🗌 Yes 2 No Cther: 2 ER/Outpatient 3□ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Fo the Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

1028

JAMES

BLOXOM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2005 ▶

31. Date filed (Month, Day, Year)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY

32. Registra/s Signature

505

DR , SALISBURY

			1 - For Stete Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of H tificate of I	lealth and Death	l Mental Hy	giene Reg. No.	2005	13438
			1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month	eath Day	Year	3. Time of Death
3	Physici /Medic		Agnes Bos	ston					March		2005	5:00 Ma
	Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location of De	ath		County of Death	
			Fairfield Num	sing Ho	ome		Crowns	ville		A	nne Aru	indel
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi		rth	9. Birthp	lece (State or Foreign
	Director		215-28-1606	1□M 2O F	88	Yrs.	William Days	riouis ivii			A	yland
	P .		Usual Residence of Decedent		140.0							
	arylar phoy	-	10a. State 10b. County		10c. CI	ty, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	cto	Maryland Anne	Arunde	el An	napol						71
	∯ o d	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cour	itry?
	ath v	rai	916 Smithvil				2140				USA	
	tems	Funeral	11. Marital Status	Armed			Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)	0- 1	 Race - Americ Black, White, 	
0	orl	by Fi	1 Never Married 2 Marr 3 XWidowed 4 Divorced	If Yes, (2⊠ No Sive		1□Yes 34□No	Specify:			Specify: B]	ack
3	within 72 hours after death with the Maryland ene. Than "natural" or tems 23e or 28e-f ehow he Modical Examiner must be notified at			Year or	Dates:	160 Danie				1 401 16		
2	"naf	Completed	15. Deceden (Specify only highe	st grade completed	1)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	durina most of w	vorking	166. Kir	nd of Business/Ind	dustry
Z	within than	Щ	Elementary/Secondary (0-12) 11th	College	(1-4or 5+)		Domes				Drizato	Family
V 5	filed Hygid Sther	ပိ	17. Father's Name (First, Middle,	Last)	. 0		DOMes		ame (First, Middle			e ramily
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of them 27 is marked other than "natural, or tems 28e or 28e-f show eny injury or other traumatic event, the Modical Examinat must be notified at once.	00	Jack Jone						sabelle		-	
2	should be nd Mental marked c	2	19a. Informant's Name/Relations	-		19b Mailir	g Address (Street a					Code)
	d 2 s th an 17 ls				١		100					
บ์	1 and Health em 27 Ither to		Reginald Hich	(8 (501)	20b. l	Place of Dispo	5 Smithy sition (Name of		Date AIIII	_	cation - City or To	
2	Pages nent of int: If It iry or o		1 Burial 2 ☐ Cremation		n State Bes	cemetery, cren staate	natory or other plac Memoria	a 1				
Daltillio	it. Pi		 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service 		Par	k"	. Name and Addres	4/	2/05	Anna	polis,	bM
מ	Depar Impo	١,	21. Signature of runeral Service	1	···	W: 8			ns Mort	uarv	, P.A.	
			23a. Part1. Enter the disease, or		00 783			St. Ai	ns Mort	s, M	á. Pżłąc	Approximate
			shock, or heart failure. List	only one cause or	each line.		ar the mode or dyni	y, such as card	ac or respiratory a	xiiost,		Interval Between Onset and Death
Î	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a //	Shirah		ruman	10				Tweek
	/Medical Examiner		, and the second	Due t	o or as a consec	quence of						
		-	Sequentially list conditions,	b	o (or as a consec	mence o//:						
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a consec	quence ory.						
_	xecut and II-trar	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a consec	quence of):						_
00/0	cate be executed physician and the burial-transit	a m			,	. ,						
0	phys phys the	dicai		d								
XO	certifi nding use as	/Me	IF FEMALE:	23c. if yes, o	utcome of pregn	ancv				,	2d Data of daling	
0	w requires that the death certif been signed by the attending should be detached for use a:	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 Feta	al death 3 🗀	Ectopic pregnancy Other (specify)				3d. Date of delive Month	Day Year
5	he de the	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	9□Unk		36au 3 _	Cities (apacity)					
7.	that t ed by detai		Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to th	e cause of death?
ב ב	sign d be	d by	Dem un tro						10	Yes 2]No 3 ☐ Prob	ably 4 📆 Unknown
BCOLD	The law requires that the te has been signed by th rage 2 should be detache	Completed	- Coproblem						04- 146-		0.45 144	/
ອ	has has	d E							24a. Was		prior to cor death?	psy findings available npletion of cause of
									1 ☐ Yes	2 No	1 ☐ Yes	20 No
VII	ding Physicien: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 15			Dthe	or of the	eath (Check only			
5	Phys this aldir	2	1 Yes 2 No	11		ER/Outpatien	1 3LI DUA	4 X Nursing	Home 5 Res)
<u> </u>	ling l	lo	1 Matural 5 ☐ Pendin	g (Mo	e of Injury onth, Day Yeer)	28b. Time of Injury	28c. Injury Work	rat (? Yes 2 ∐ No	28d. Describe	now injury	occurred	
SION	ttend death tor: the	cat	Accident investig	not be	an of lainer. As h	ama farm at-		195 2 100	295 Location	Ctroot one	Number or Rura	I Parita Niverbar
\leq	or A after Direction by	Certification;	4 Homicide determ	ined 200. Fla	ding, etc. (Speci	fy)	eet, factory, office		City or To	wn, State)	rivumber or Mura	r noute ivamber,
-	pital purs surs seral l		20n Carifor 1/17 Cartifolis	e Physician, To t	no boot of multa-							
	To the Hospital or Attending Physicien: state 24 hours after death as a feet this certification to the Funeral Director. After this certification the funeral director, the funeral director.	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	Examiner: On the	ne best of my kno basis of examina inner stated.	ation and/or inv	occurred at the time restigation, in my op	ie, date and pla pimon, death oc	curred at the time,	date and	and manner as st place, and due to	the cause(s)
	o the o the omple	Med	29b. Signature and totle of certifie		or stated.		29c. License	number	,	29d. Date	signed (Month, i	Day, Year)
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	7		20 Name of distance of the control o	uha namalata	upo of Asset (II	m 99c) /T	U 50	5953		1/5	0/05	
	1		30. Name an oddress of person	who completed ca	use or peetin (Itel	MAA N	1/3 Arma	L. B. 11.	2-1 4-1	11/	3 of to	MD 21113
1	Sta	to	31. Date filed (Month, Day, Year)	1 32	AUUL Rustrar's Sign	ature 1	1 JIIIII	DOWN MA	ay #-/1	VO C	WENTER	IVID dilis
*8	Ste Registi		ADD (1 0005	Market 2		down					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** BETTY JOAN BROWN 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** If Under If Under 24 Hrs Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🗓 F WV 234-62-2816 JULY 28, 1937 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic evant. The Medical Examinar must be notified at 1X Yes 2 □ No Director HAMPSHIRE ROMNEY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Itams 23a 26757 USA 195 CHARLEVOIX PLACE death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify. Specify: WHITE þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is merked other than "nat any injury or other traumatic event, Ine Medica once. Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS SEWING FACTORY 12 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE THOMAS BROWN FANNIE SUSAN LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 73 VALLEY ST., ROMNEY, WV 26757 PATRICIA E. SHROUT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State BRANCH MOUNTAIN 4/15/2005 THREE CHURCHES, WV * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 22. Name and Address of Facility SCARPELL SHAFFER-WARNICK FH, 230 HOME PA FOR ., ROMNEY, WV 26757 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cordial Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rono Sequentially list conditions, if any, reading to introductions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year ģ 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe 1 Yes 2 No certificate Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dirac completely filled in b 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Externior: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar

31. Date filed (Month, Day, Year) APR 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

D0056355

04/13/05

21502

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Рм 2005 1250 Apri1 11 William Sylvester Barnett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E1kton Ceci1 311 Elkton Boulevard 8. Date of Birth (Month, Day, Year) NOV 17, 1922 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□F Months Hours Pennsylvania Director 219-12-9207 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 TyYes 2 □ No Completed by Funeral Director E1kton Maryland Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 311 Elkton Boulevard United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian Black, White, etc. or Items 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Year or Dates: War II 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other traumatic event. The Medic once. (Specify only highest grade completed) Automobile College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Materials Handler 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William P. Barnett Olive Bea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Ruth Lorraine Barnett/Wife 311 Elkton Boulevard, Elkton, Maryland 21921 20b. Place of Disposition (Name of Gilpin Manor 20c. Location - City or Town, State 20a. Method of Disposition April 14, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Elkton, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee bes Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** econdar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transif certificate be executed 1 cul that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 10 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Tyes 1 ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.
To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Certification: To 1 Yes 2 1 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) -29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M .D Javantilal 4+1 31. Date filed (Month, Day, Year) State 2 APR 0 Registrar

			1 - For State Registrar	State of Ma	aryland / Dep		f Health and			13441
	Physic	ian	Decedent's Name (First, Middle, Las.	t)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi		George Chris			1	VIIIVINI - S	April 3,	2005	1:16 p M
4	Examir	ner	4a. Facility Name (If not institution, give				n, or Location of De	ath	4c. County of Deatl	
	Euroval		Suburban Hospita 5. Social Security Number 6. Se		e (In yrs. last birthday)	Bethes If Under 1 Ye		rs. 8 Date of Birth	Montgom	
	Funeral Director			XM 2□F	67 Yrs.	Months Day				nplace (State or Foreign untry)
	р.		Usual Residence of Decedent					5411.10,1	yyo wasi	THE COLL DC
	aryiar show	_	10a. State 10b. County Montgot	merv	10c. City, Town or Lo					10d. Inside City Limits
	Be-f	ecto		пету	Layto	nsville				1 ☐ Yes 2\ No
	with t	ä	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	eath	eral	21713 Goodstone	Drive 12. Was Decedent 6	Ever in U.S. 13.		20882	(Specify Ves or No	U.S.A. 14. Race - Ame	ican Indian
(0	r iten	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	io Tatai T T			(Specify Yes or No- erto Rican, etc.)	Black, White	
03	raf, o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 21XIN	No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or items 23e or 28e-1 show ha Medical Examirar must be rodiffed at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual Occ	cupation ne during most of w ired)	vorking 1	6b. Kind of Business/I	ndustry
121	vithin ne. hen'	Idm	Elementary/Secondary (0-12)	College (1-4 or 5		<i>DO NOT use ret</i> ealtor	rired)		Real Esta	te.
	filed y		17. Father's Name (First, Middle, Last)				18 Mother's N	ame (First, Middle, M		
an	d be ental ced o	To Be	Christ D.	Chapin				na Calomir		
Maryland	should and Men marke umatic	F	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Stre			City or Town, State, Z	ip Code)
	and 2 salth a n 27 is		Glenda Chapin/ Wit	fе				e Laytonsv		20882
ore,	of He of He r othe		20a. Method of Disposition	D	20b. Place of Dispo cemetery, cre	osition (Name of	olace)	Date 2	0c. Location - City or 1	Town, State
Ë	Pages nent of I ent: If its ury or o		¹X☐ Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,		St. Gabri		4/7,	/05	Potomac, M	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Department of Health and Mental Hygiene, importent: if item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at ance.		21. Signature of Funeral Service Licens	ee 2 m					ler's Sons	, Inc.
	g ⊖ = e o		Jul 17.	700				enue NW WD		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not en e. Myocardial a consequence of):			ac or respiratory arre		Approximate Interval Between Onset and Death hour
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.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnar Other (specify)			23d. Date of deliving Month	very Day Year
rds, P.	quires that n signed b	by	Part If. Other significant conditions co	ntributing to death bu	it not resulting in the u	nderlying cause	given in Part I.		acco use contribute to	the cause of death? bably 4 □Unknown
Records,	The law requir cate has been si page 2 should	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Vital	sician: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only one		20.110
of V	Physician: r this certific ral director,	은	1 □ Yes 2 No	Hospital: 1 ☐ Inpatier		it 3□ DOA	Other: 4 🗆 Nursing	Home 5 Residen	ce 6 Other (Speci	fy)
Division o	ding After fune	ation:	27. Manner of Death 12 Natural 2 Accident 5 Pending investigation	28a. Date of Injun (Month, Day	Year) 28b. Tîme o Injury	28c. In W	lury at Vork? □ Yes 2 □ No	28d. Describe how		
É	itei or Attencus after deathrel Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . <i>(Specify)</i>	eet, factory, offic	ee .	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
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	(5)		30. Name and address of person who co					11/0/		
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	Physici	an	Decedent's Name (First, Middle,)	Last)						2. Date of D Month	eath Da	y Year	3. Time of Death 7:45 Р м			
	/Medic		Alfred Carmel							Apri1	1	2005				
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ŀ	Funeral Director		5. Social Security Number 579–30–5897	. Sex 7. Ag 1 ☑ M 2 ☐ F	96	ast birthday) Yrs.	Months	Days	Hours Min.	8. Date of B	ay, Year)	9. BIRI	hplace (State or Foreign untry)			
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	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits			
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36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		1 🗆 Yes	2 ∏ No	Specify:			Specify: Wh	ite			
8	be filed within 72 hours after death with the Maryland ital Hygiene. or other than "natural", or Itams 23a or 28a-f show evant, the Medical Examinar must be motified at	ed t	15. Decedent's		1	16a. Dece	dent's Usua	al Occupa	ation		16b K	ind of Business/	Industry			
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Maryland 21215-0036	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship				-		und Number or Ru		-		Zip Code)			
	s 1 and 3 f Health itam 27 othar tr		Rita Veneziani /	Daughter					h St., I							
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Bai	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lie	P R					s of Facility Jos	-						
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4	that t		Part II. Other significant condition	s contributing to death b	out not resu	lting in the u	nderlying c	ause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?			
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ta		a	25. Was case referred to medical						26. Place of Dea	1 ☐ Yes		10105	2 140			
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	To the Hospital or Atte within 24 hours after de To the Funeral Diracto completely filled in by th	Me	29b. Signature and title of certifier	0 1			290	. License	number		29d. Da	te signed (Month	h, Day, Year)			
}			> K. Shy	Mound	W		Т	5336	57		Ap	RIL OI	. 2005			
0	(10)		30. Name and address of person w	no completed cause of c	death (Item	23a) (Type,				(A n A						
1	0		10810, DARNES,	NOWN POTH	D) Ci	IINE:	202,	UA	"17 19 WI	1119, 1	up.	2878				
	Sta		31. Date filed (Month, Day, Year) APR 0 7 2	3 Registr	rar's Signat	L	A.									
	Registr	ar	MER DIE	THE PARTY OF THE P	, ,											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar4-8-05 Amend #5.Per FH PCCcr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $04/01/2005^{\text{Day}}$ Year 12:00 Рм Bruce Warren Churchill 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 04/30/1939 9. Birthplace (State or Foreign Country) Washington, DC If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Min. 1**X** M 2□ F Hours 389-34-5722 578-07-5864 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County N☐Yes 2☐No Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20817 Montgomery 6309 Blackwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Attorney Legal 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ross Taylor Warren Churchill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Wriley Rd., Bethesda, MD 20816 Devorah S. Churchill /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Mt. Comfort Crematory 04/05/05 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawlers Sons, INC. 21. Signature of Euneral Service Licensee M01378 5130 Wisconsin Ave. NW, Washington DC 20016 23a Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVALULAR ATHEROSCUEROTIC MONIMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year

Physician /Medical **Examiner**

permit. Page Department Important: fl any injury or once.

Physician

/Medical

Director

by Funeral

MD

Examiner

Funeral

Director

show

77 is marked other than "natural", or items 23a or 28e-f shov traumatic event. The Medical Evan ing the notified at

72 hours after

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Pages 1 and 2 ment of Health a ant: If item 27 is

Maryland 21215-0036

Baltimore,

Examiner use as the burial-transit and Physician/Medical been signed by the atte the funeral After death. after death Director: in by

Completed by

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Medical Certification: To

Churchill 1750m of Vital Records, P.O. Box 68760,

ivision

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown 35. Was case referred to medica

4☐Pregnant at time of death 9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

24a. Was an 1 Yes 2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

20814

3 ☐ Probably 4 Unknown

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

	examiner?		
27.	Manner of	. □ Ponding	

28a. Date of Injury (Month, Day Year) investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

2 R/Outpatient 3 DOA

28c. injury at Work? 1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred

BETHOSDA

28f. Location (Street and Number or Rural Route Number, City or Town, State) to critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

0

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

License number 31027

RD

29d. Date signed (Month, Day, Year) 05

BRIE 31. Date filed (Month 7°2005

8600 1921 CEWLGETINN

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral C

completely filled i

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2005

Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. cedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Ment 9:28 AM ckens 05 4c. Sounty of Death 4a. Facility Name (If not institution, give street an 4b. City, Town, or Location of Death Shing ton If Under 24 Hrs. f Under 1 Year Months Days 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 1 ■ M 2 XF Min. Months Hours October 12, 1937 North Carclina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State County 1XYes 2 □ No Washington 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Black 3 ¥Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Jovernment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dickens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richmond, VA 23227 521 Plantation Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8 Richmond, VA 05 4 □ Donation 5 □ Other (Specify) Forest Lawn Cem. 21, Signature of Funeral Service Licensee Na lon C Street 22. Name and Address of Facility Funeral Home, INC 814 Franklin Street, Alexandria, VA 22314 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMENTIP Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown

Physician /Medical **Examiner**

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After this certification

Director:

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requires that the death certificate be executed

Box 68760

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Division of Vital Records,

Physician

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Director

ii Hygiene. other than "natural", or Items 23a or 28a-1 ehow vent, ITS M-216.d Ex. nurst to nolified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any njury or other traumatic event. If a Modical Examiner is used.

Completed by Funeral Director

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21215-0036

Baltimore, Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical

5 Pending

investigation

^{7°}2005

6 Could not be determined

1 Yes 2 No

examiner's

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

1 🗌 Yes 2 No

3 Probably 4 Unknown

24a. Was an autopsy 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☑ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ER/Outpatient 3 DOA

28b. Time of

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of

29d. Date signed (Month, Day, Year)

30 Name and address of person the completed cau

se of death (Hem 23a) (Type, Print) reck Rd. Ft. Washington, MD una lermo

APR 0 State Registrar

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a C											24a. W au pe 1 Ye	itopsy erformed?		Were auto prior to cor death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
director, page)	25. Was case referred to m examiner? 1 ☐ Yes 2 2 No	edical	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	A Oth	05		h <i>(Check on</i> me 5 ☐ R		6 □Ott	ner (Snecifi	ν)
S =	1	27. Manner of Death	ending ivestigation	28a. Date (Mo	,	28b. Time o Injury	_	8c. Injun Worl		Ī	28d. Descril				<i>,,</i>
oire in b		3 Suicide 6 0	ould not b etermined	200. Flat	e of Injury - At h ding, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory	, office				n <i>(Street a</i> Town, Stai		ber or Rura	l Route Number,
To the Funeral I completely filled				niner: On the	ne best of my kno basis of examina nner stated.										
To the Funeral is completely filled		29b. Signature and title of c	ertifier	e L. A.	MAT)	290 D	. License	number	5 1	9	29d. D.	ate signe	ed (Month,	Day, Year)
)		30. Name and address of p	ne	completed cau	eh r	1. D.		- Gr	rod L	-ncl	Kwa	dla	aho	m M	p20706
State Registrar		31. Date filed (Month, Day, APR 0		2.	Registrar's Sign	ature	K)					,		,	

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: within 24 hours a To the Funerel [

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Ollmin

5 -10 DIECN 32. Redistrar's Signature 31. Date filed (Month,

2005

cause of death (Item 23a) (Type, Print)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 5/05

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2005

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Donald Kenneth Fultz 6:35 P APRIL 2005 /Medical 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LAPLATA
If Under 1 Year | If Under 24 Hrs. CIVISTA MEDICAL CENTER CHARLES 8. Date of Birth (Month, Day, Year)
Time 11,1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1(**X**M 2□ F Months Hours Virginia 227-44-9970 67 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, the Machael Examinating rust be notified at Yes 2 No Directo Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Park Square Ct. 20640 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □¥es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ voivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry If Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Bartender Bar/Store permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If Item 27 is marked other eny injury or other treum... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Kenneth Fultz Leslie Ruth Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Park Square Ct., Barbara Donaldson Sister Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Date 20a. Method of Disposition 20c. Location - City or Town, State 8,2005 Service Alexandria,Virginia 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral 22. Name and Address of Facility
Williams Funeral Home,
4270 HAwthorne Rd., In 21. Signature of Funeral Service Licensee 20640 Md. M00668 Indian Head, 23a. Part1. Enter the disease, or complications that shock, of hear failure. List only one cause on Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Sanc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, each of to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 - No or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1-Inpatient 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending Injury death. 1 🗌 Yes 2 🗌 No after death 2 Accident investigation filled in by the 3 - Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

hawak

APR 0 7

BAIG

KAMAKSHI

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2005

6620 CRATN HWY

. Pogistrar's Signature

D-0056949

STE 102 LAPLATA MD 20646

05

			1 - For State Registrar	State of Mary		artment of rtificate of		d Mental Hy	giene	7 11 11.4	13452
	Physici	20	1. Decedent's Name (First, Middle, Las	t)				2. Date of De			3. Time of Death
	/Medic		Glen Lee	Fischer	2			April	17,	2005	1:10 P M
	Examin	ıer	4a. Facility Name (If not institution, give Holy Cross Hospi				or Location of De	eath		County of De	
	Funeral		5. Social Security Number 6. S		yrs. last birthday)		r If Under 24 F		rth	lontgon	
	Director		467-98-2775	X ^{M 2 F} 54	Yrs.	Months Days	Hours M	lin. (Month, Da	ay, Year)	0 Ok	Birthplace (State or Foreign Country) Lahoma
	pu *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo						
	Aaryla f shore	ō			•						10d. In side City Limits 1. Yes 2 No
	the the	Director	VA 10e. Street and Number		Richmond	10f. Zip Code		T	10a. Citi	zen of What	Λ
	h with	al Di	17 N. Granby Str	eet		23220)			J.S.A.	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of	Hispanic Origin?	(Specify Yes or No		14. Race - Ar	merican Indian,
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ሺ No If Ye <i>s</i> , Give		1 ☐ Yes 2 No		ronto ritoan, etc.)		Black, W	nite, etc. Inite
Ş	filed within 72 hours after death with the Maryland Hygiene ther than "naturel", or Items 23a or 28e-f show with the Marikal Examination Inditied at	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a Decer	dent's Usual Occu	Ination		16h V		
7.	nin 72 In "ne Wedlic	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retin	e during most of v ed)	working	160. K	nd of Busines	ss/industry
212	d with giene er tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Vice F	resident	:/Manage:	r	Con	sultin	ıg
<u>8</u>	0 = 0 5	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		,	
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is and Mental Hygiene is marked other than "neturel", or litems 23a or 28e-f show eumetic event, the Mydical Erandree mast be notified at	P	Roland Fischer	n. 12 22				thy Giess			
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic er once.		19a. Informant's Name/Relationship (7) Michael E. Rider	• • • •		ng Address <i>(Stree</i> J. Granby		Rural Route Numb			
	Heal Heal tem 2		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of		Richmon Date			3220 or Town, State
Ë	Pages ent of nt: if i		1 ☐ Burial 2 🔀 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer Bennett C	natory or other pla 'remators		19/2005	Glen	Aller	, Va
altimore,	permit. Departm Importe any inju		21. Signature of Funeral Service Licen		22	2. Name and Addr	ess of Facility	3215	Chite	harr Ar	
<u> </u>	8 9 E 8		Samuel C.	Harrisin	Be-	ennett Fi	meral H	ome Richm	ond,	Va.	23230
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compands, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Saluantially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPTICEN Due to (or as a co Due to (or as a co ACALCULA	MIA nsequence of): THROMBOCY nsequence of): DUS CHOLE	TOPENIC	PURPURA				Approximate Interval Between Onset and Death
8760,	iicate be executed physician and s the burial-transit	dical Ex	rossining in south, East	Due to (or as a condition of the details of the det	nsequence of): IC ANAFMI	'A					
.O. Box 6	ithe death certii y the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 []Ectopic pregnand] Other (specify) _	cy		2	23d. Date of d Month	delivery Day Year
S, D	res that igned b	by P	Part II. Other significant conditions of		t resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco u	se contribute	to the cause of death?
ord	w require been sig should t	ted	REFRACTORY THROM	BOCYTOPENIA				_ 10'	Yes 2[X No 3□	Probably 4 Unknown
I Record		Completed						24a. Was autor perfo 1 Yes		24b. Were prior to death'	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital: 😎		10		Death (Check only o	one)		
	Phys	. To	t ☐ Yes 2X No 27. Manner of Death	Inpatient	2 ER/Outpatien 28b. Time of	I JUDOA		g Home 5 Resident			pecify)
on	ding Ith. : After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	Wo	ork? Yes 2 No	200. Describe	now injur	y occurred	
Division of	To the Hospital or Attending Physicien: with 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	ertification:	3 Suicide 6 Could not be determined		At home, farm, str pecify)			28f. Location (: City or To			Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C	29a. Certifier (Cleck only onle)	ysician: To the best of my liner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ace, and due to the courred at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1A 0 - 22:	4.4	29c. Licen	se number		29d. Date	e signed (Mo	nth, Day, Year)
٠			> 2.2	ANCHALI	YV I	D - 5	9284		02	4/17/	2005
	15		30. Name and address of person who			•				,	
			Dr. S. Shamim 31. Date filed (Month, Day, Year)	1500 Forest		ad, Silv	er Sprin	ng, MD 20	0910		
	. Sta Registr		APR 2 0 21	005	4 4						

			1 - For Stata Registrar	State of I	Maryland /	Depa		of He	ealth a		_		005		13453	3
П	Physici	an	Decedent's Name (First, Middle, Last, ———————————————————————————————————								2. Date of De. Month	ath Day	Yea	ar	3. Time of Death	
	/Media		IDA H. GUDELS								March	30	200	5	5:12 P	М
4	Examir	ner	4a. Fecility Name (If not institution, give	_	er)		4b. City, To						County of D			
			Holy Cross Hospi 5. Social Security Number 6. Sec		Age (In yrs. last b	oirth day)	Silve If Under 1		Sprin		8 Date of Bir		ntgom		ano (Ctata as Fassi	
	Funeral Director			M 2⊠F	96	Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da Feb. 4,	y, Year) 1909) 7	Counti	ace (State or Forei y) :1 a	ign
	ס		Usual Residence of Decedent													
	show	_	10a. State 10b. County		10c. City, To									10	d. Inside City Limit	
	Ba-f	ecto	Maryland Montgome	ry	511	ver	Spring								1⊠Yes 2□N	10
	with the	Funeral Director	10e. Street and Number	A 4- 16/1	10		10f. Zip C						en of What	Count	у?	
	eath	era	8201 16th Street	APC 1/4		13	209		nanic Orio	nin? (Sne	cify Yes or No		S.A.	marica	n Indian	
(0	riten	Fun	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2	es?					Puerto F	cify Yes or No Rican, etc.)		Black, W	hite, e	tc.	
036	raif, o	b	3	If Yes, Give Year or Date	es:		1□Yes 2፟	No P	Specify:			3	Specify:	Whi	te	
21215-0036	within 72 hours efter death with the Marylend ene. than "natural", or iteme 23e or 28e-f show he Medical Examinat musi be rodified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16	a. Dece	dent's Usual (Occupa done di	tion urina most	of working)a	16b. Kin	d of Busine	ss/Indu	ıstry	
121	han han	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work DO NOT use									
	Hygie Hygie thert nt, m		12th 17. Father's Name (First, Middle, Last)			HO	memake		18 Mother	r's Name	(First, Middle,		n Hom	e		
an	d be	To Be	Jeremiah Zukoff								Kohen	Maidell	omame,			
Maryland	shoul nd Me mark	F	19a. Informant's Name/Relationship (Ty	pe, Print)	19	b. Maili	ng Address (S	Street a			ROTTETT	er, City or	Town, State	e, <i>Zip</i> (Code)	_
	od 2 27 is		Norman Hochman/So	n		5916	Edson	La	ne, R	Rockv	ille,	Mary1	and 2	2085	52	
Jre,	item othe		20a. Method of Disposition		20b. Place		sition (Name				ate		ation - City			
<u><u>=</u></u>	Page nent of Live in the D	Y.	1 X Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	emoval from Sta	ate ;		ld Ceme		- 1	04/01	1/2005	Fall:	s Chu	rch	, Virgin	ia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show mithough to other treumatic event, the Medical Examination at Ance.		21. Signature of Funeral Service Licens) ⁰	A	H2	Name and	Address I NAT	ol Facility	ÍNERA	AL HOME	. TNO	C.			
<u>—</u>	2012		Nancy A. Y	e ce	tu	111	1800 Ne	w H	lampsh	hire	Ave, S	ilve	r Spr	ing	, MD 2090	04
8760,	Cate be executed /Medical Examiner she burial-transit	ledicai Examiner	23a. Part1. Enter the sease, or complishock, or half failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	s Syndro as a consequence eral Pne as a consequence as a consequence	me e of): umor uor,									Approximate Interval Between Onset and Death	
P.O. Box 68	the death certifi by the ettending ached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 Live birth	me of pregnancy n 2 Fetal deal t at time of death n		Ectopic preg Other (spec					23	3d. Date of Month		y Day Year	
Records, P	quires that n signed t		Part II. Other significant conditions col End Stage Renal					se give	n in Part I.			obacco us Yes 2∑			cause of death?	wn
Ö	s been si s been si s should	Completed									24a. Was	an	24b. Were	autops	sy findings availab	ole
Re	The la	mo										rmed?	prior death	to com	pletion of cause of	f
Vital	ian: rtifice stor, p	Be C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		- 1 - 1	es 2	□ N0	
1	Physician: r this certificanal director, I	To E	examiner? 1 ☐ Yes 2 🛣 No	lospital: 1 🔼 Inp	atient 2 ER/C	Outpatier	nt 3□ DOA	Othe			ne 5 Resid		Other (S	pecify)		
n of	Attending Physician: The lay death. I death. Inclus: After this certificate hes by the funeral director, page 2.		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Day Year)	. Time o Injury	f 28c	. Injury Work	at ?	2	8d. Describe I	now injury	occurred			
Sio	Attending r death. sctor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				M		es 2 N							
Division	or At after of Direction by	Certification	4 Homicide determined	28e. Place of building	Injury - At home, , etc. (Specify)	larm, st	eet, Jactory, o	office		2	81. Location (3 City or Tox		Number or	Rural	Route Number,	
_	To the Hospitel or Attent within 24 hours efter deatl To the Funerel Director; completely filled in by the	Medical Ce										as sta	ted. he cause(s)			
	To the Mithin To the	Me	29b. Signature and title of certifier	29c. L	icense	number			29d, Date	signed (Mo	onth, D	ay, Year)				
	/		· K. Snyan	NOW	our		D	5336	57			Marc	h 31,	20	05	
	5		30. Name and address of person who co Shyamsundar Raja	mpleted cause n, M.D.	of death (Item 23a , 10810) (Type, Darn	Print) estown	Ro	ad, S	Suite	#202,	Gait	hersb	urg	, MD 208	378
	Sta Regist		31. Date liled (Month, Day, Year) APR 0 5 20	32 Reg	jistrar's Signature	Sec.	we									

			1- For State of Maryland / Department of Certificate of Maryland			ene)5	3454
	Physicia		Decedent's Name (First, Middle, Last) MARGARET ELLISON GRAVES		2. Date of Death Month March	_	2005	3. Time of Death 8:30 A M
	/Medic Examin			n, or Location of Death	TIGE OIL	4c. County	of Death	0.30 11
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes	ar If Under 24 Hrs.	8. Date of Birth	Vearl	9. Birthp	lace (State or Foreign
	Director		301.10.0657 1□ M 2⊠ F 91 Yrs. Months Day Usual Residence of Decedent	rs Hours Will.	April 19	7,1913		Union, OH
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examiner a ust to routified at	'n	10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits 1 X Yes 2 □ No
	the M	Funeral Directo	Maryland Howard Laurel 10e. Street and Number 10f. Zip Code	9	10	g. Citizen of	What Cour	
	3a or	ā	8524 Pineway Drive 20723			U.S.		,
	death	nera		of Hispanic Origin? (Spe Juban, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Americ	
9	illed within 72 hours after death with Irlygiene. It Hygiene, or items 23a other than "natural", or items 23a yent, the Madical Examiner roust to	by Fu	1 Never Married 2 Married 1 Yes 2 No		riloari, oto.)		ick, White, fy: Whi	
0000-c	tural'		3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occ	cupation		6b. Kind of B	lusiness/Inc	dustry
2 2	nin 72 '. In "na Medic	Completed	(Specify only highest grade completed) (Give kind of work dor life. DO NOT use retired in the context of the co	ne during most of work tired)	ing	ob. Rind of b	, doi:1003/111	auony
7	od with	Com	2 Years Administrat			U.S. G		ment
alla	be file	Be	17. Father's Name (First, Middle, Last) Carey Ellison Robuck	18. Mother's Name		faiden Sumai	me)	
7	permit. Pages 1 and 2 should be 1 Department of Health and Mental 1 Importent; If item 27 is marked or any injury or other treumetic eve	2	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Stre</i>	Clara	Brodt	City or Tour	Stato 7i-	Cadal
Z	id 2 sl ith and 27 Is r treur		Karen A. Lacy/Granddaughter 8524 Pineway			-		
ā,	s 1 an f Heal item 2	1	20a. Method of Disposition 20b. Place of Disposition (Name of			Oc. Location		
aitimore,	Q of E		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Rock Creek Cemet		2/2005 V	Vashin	ton.	D.C.
a	rmit. partm porte y inju			dress of Facility NALDI FUNES			, ,	
מ	825 5 8		Manay M. Vercen 11800 Net	w Hampshire	Ave, Si	llver S	Spring	2. MD 20904
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failude. List only one cause on each line.	tying, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
1	Inysician /Medical		Immediate Cause (Final disease or condition resulting in death) Massive Cerebral Hemorrha	age Right C	Cortex			24_Hours
	Examiner		Due to (or as a consequence of):					
	** 	Jer	Sequentially list conditions, if any, leading to immediate b. Hypertensive Cardiovascul		-	Years		
	cuted nd ransit	Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events c.					
Ď,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
9/9	certificate be executed iding physician and ise as the burial-transit	dicai	d				-	
Σ Σ	eath certifica attending ph for use as tf	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d D	ate of delive	201
X Q	death of attention ad for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No				onth	Day Year
r Ö	that the de ned by the a detached f	hys	9 Unknown					
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101	g Phy er this seral c		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. In		28d. Describe ho			y)
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	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Check only one) Amount of the basis of examination and/or investigation, in m and manner stated.	e time, date and place, by opinion, death occur	and due to the ca red at the time, da	ite and place	anner as s , and due to	tated. the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely illied in by the funeral director,	Me	29b. Signature and title of certifier 29c. Lice	ense number	29	d. Date sign	ed (Month,	Day, Year)
	2/		NAMA A. ACHARIATA PARO	-26331		Apri1	4, 2	005
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marta A. Schneider, M.D., 5401 MacArthur B1	.vd., N.W.,	Washing	ton, D	.c. 2	0016
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 5 2005 32/Registrar's Signature					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Mary Louise Gabriel 03, April 2005 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🕏 F Director 75 208-22-5185 04/12/1929 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No Montgomery Village MD Montgomery Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 19504 Tiber Court 20886-3913 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any Injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Antique Dealer Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen S. Snyder Lloyd G. Taylor or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19504 Tiber Court, Montgomery Village, MD 20886-3913 Armand O. Gabriel, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 04/06/2005 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service bicensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Year Month Day 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🏹 Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 🗌 Yes 2 □ No 1 ☐ Yes 2 X No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{X}$ Other (Specify) Hospice 1 ☐ Yes 2 🗙 No 2 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No efter death Director: 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospitel o within 24 hours eft To the Funerel Di to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and the of pertiper 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Charles Harrison, MD, 31. Date liled (Month, Day, Year) 32 Registrar's Signature State 05 2005 Registrar

PM 5-02419 loria Gank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1a	Gank		For State	State of M	1aryland			of Health a		_	6 U	05	13456
			Registrar 1. Decedent's Name (First, Middle	a, Last)			incate	O Death		ate of Death	No.		3. Time of Death
	Physicia	_	Gloria	Deloris		Gank				Month Oril	Day 06. 20	Year 005	10:50A M
	/Medic Examin		4a. Facility Name (If not institution		r)	Ourne	4b. City, T	own, or Location of		7	4c. County		10.00A
	LAGITIT	Ŭ.	195 Trailer Cou	ırt Road				0akland			Garre	ett	
	Funeral		5. Social Security Number		kge (In yrs. Ia	ast birthday)	If Under 1		24 Hrs. 8 F	ate of Birth Month, Day, Y			place (State or Foreign
	Director		220-58-1012	1 □ M 2 ☑ F	75	Yrs.	Months	Days Hours		r. 30,	1930		est Virgina
	D		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	vention					1	0d. Inside City Limits
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က်	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or items 23s or 28s-f show ant, it s Macilcal Exactler must be natified at	Completed	15. Deceden (Specify only higher	t's Education		16a. Dece	dent's Usual	Occupation done during mos	st of working	16	b. Kind of Bu	siness/In	dustry
2	thin 6	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use	retired)	n or working				
7	ed w ygjer ser th	Cor	12th				Н	ousewife				Home	
_	0 - 0 %	Be	17. Father's Name (First, Middle,		-				er's Name <i>(Fir</i>			θ)	-
2	2 should be filed within 72 hours after death with the Marylan and Menhal hygiene is marked other than "natural, or items 23a or 28a-f show is marked other than "natural, or items 23a or 28a-f show aumatic event. It a Madical Examiner must be natified at	^L	Hunter	Boyd	Bows	7.7			zel		erisa	C+-+- 7:	Sisler
Z	d 2 sl th and 7 is r traur		19a. Informant's Name/Relations Harold G. Gan					Street and Number					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 is marked any injury or other traumatic ev <u>once</u> .		20a. Method of Disposition	.K/ nusband	20b. PI	ace of Dispo emetery, crei		er Court	Date		nd, Md		
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Ba	Den Imp any		> Bull 1	Mon		V.		t Funeral			S. Sec land,		
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sio	Attending of death.	cati	2 Accident investi	gation			М	1 ☐ Yes 2 ☐					
Division	after d Direct Jin by	Certification:	4 Homicide determ	nined 286. Place of I	etc. (Specify	me, farm, st	reet, factory,	office		City or Town, .		er or Hura	al Route Number,
	Hospital 24 hours a Funerel D tely filled		29a. Certifier 1 ☐ Certifyii	ng Physician: To the be	at of my know	wlodgo door	h assumed a	t the time, data or	nd place, and	due to the equ			totad
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2X Medical one)	Examiner: On the basis and manner	of examinat	tion and/or in	vestigation,	in my opinion, dea	ath occurred a	t the time, date	and place,	and due to	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	,	00		29c.	License number		290	. Date signer	(Month,	Day, Year)
)			Hoto (100 - 10	Wil	~~		OCME			April	07. 3	2005
	(0		30. Name and address of person	who completed cause of	death (Item		Print)	2.2.2				99	
_	4		PATRICIA A	ronica-t	MINK	Sul) 11	1 Penn S	Street	Baltimo	ore, Ma	aryla	and 21201
	Sta		31. Date liled (Month, Day, Year,	32. Regis	strar's Signa	ture							
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Year April 10:20 PM 6 Jesse Glenn Green 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Allegany Eale Lonaconing Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 6, 1915 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Days Hours 1₩ 2□ F Months Maryland 89 215-16-4409 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b County 1 ☐ Yes 2 No Barton MD. Garrett 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 7752 Westernport Road 21521 United States 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes **X**XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes XX No Specify. Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) unknown College (1-4or 5+) Farming Farmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ellen E. Clark William Ellsworth F. Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17200 Livingstone Road, Accokeek, Maryland 20607 Norma Rollins/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 04/09/ 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Barton, Maryland Mt. View Cemetery 2005 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days Cerebrovascular accident Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

use es the burial-transit

or Attending Physician: The law requires that the death certificate be executed

After this certificate

after death.

To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funerai

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Completed

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantice must be notified at once.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medical Examiner Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Prior Cerebrovarcular accident þ Adeno carcinoma of prostate Completed Right Lower lobe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 No 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 T Homicide

29a Certifier (Check only one)

1 Excertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TIGGREENING PHYSIGHT: TO the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and manner as stated.

2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and thie of certifier _no rown

D0021488

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

20 Daylas Avenue, Conacuing, Med. 21539 200 Segistra Signature 31. Date filed (Month, Day,

State Registrar

For AMEND# 30 4/4 1 - State AACO HEALT	1/05 State of Maryland / D		a * h	giene 2005	13458						
1. Decedent's Name (First, Middle	e, Last)		2. Date of Dea Month	Day Year	3. Time of Death						
Physician Albourt	Gast		03/	30/24-5	21:00 M						
Examiner 4a. Facility Name (If not institution		4b. City, Town, or Loca		4c. County of Deat							
North Arundel Funeral 5. Social Security Number	6. Sex 7. Age (In yrs. last birti	hday) If Under 1 Year If U	Burnie Jnder 24 Hrs. 8. Date of Birtl Jury Min. (Month, Day	9 Birt	Arundel hplace (State or Foreign buntry)						
Director 217-24-4881	1\2 M 2□F 75 Y	rs. Months Days Ho	ours Min. (Month, Day Dec. 2	1929	MD						
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits						
with in the Maryland in the Ma	MD Anne Arundel Glen Burnie										
of the street and Number 10e. Street and Number 265.											
365 Phrine Roa		2106		USA 14. Race - Ame	rican Indian						
11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No	If Yes, specify Cuban, Me	sic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	Black, Whit	e, etc.						
3 □ Widowed 4 □ Divorced	If Yes Give	1 ☐ Yes 2∯ No Sp	pecify:	Specify:	White						
21215-0036 and within 72 hours affected withi	it's Education 16a. st grade completed)	Decedent's Usual Occupation (Give kind of work done during	g most of working	16b. Kind of Business	(Industry						
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N post of the same	_		Mother's Name (First, Middle,								
Albert Max 19a. Informant's Name/Relations			Leona Clark								
C			Number or Rural Route Numbe	-							
Jeanne Gast/W		565 PNTINE ROAG Disposition (Name of y, crematory or other place)	d, Glen Burnie	20c. Location - City or							
1 □ Burial 2 □ Coremation 1 □ Donation 5 □ Other (3	3 Removal from State	y, crematory or other place) Crematory	Apr. 1, 2005	Baltimore	, MD						
	4	22 Name and Address of	Sons, P.A. Sev	erna Park 3	Funeral Home						
	A filly	495 Gov. R1	tchie Hwy, Sev	erna Park.	MD 21146 Approximate						
Immediate Cause /Final	r comblications that caused the death. Do not only one cause on each line.			1651,	Interval Between Onset and Death						
/Medical disease or condition resulting in death)	a	Arters 1)	(1 ea) ~								
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9 = 0 1 1 Yes 21 No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Ou	Othor	Nursing Home 5 Resid		ocify)						
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30 Name and address of perso											
han S.Ch	who completed cause of death (Item 23a)	(Type, Print) (SKI	PAHADOR MOME	ED SICE	91						

		1	For Stata Registrar		State	of Man	yland /	•	rtment of tificate o			•	giene Reg. No	7111)5	134	59
3			Decedent's Name	(First, Middle, L	ast)						2	2. Date of De	ath			3. Time of Dea	ıth
	Physiciar Medica/		Carol B.	Haberman	n						1	Month March	31,	200	rear 05	10:25	A^{M}
	Examine		la. Facility Name (If	not institution, gi	ive street and nu	ımbər)			4b. City, Town	, or Location of	of Death		40.	County of	Death		
			Suburban						Bethes					ontgo			
	uneral irector		5. Social Security No. 105–30–16	615	Sex 1☐M 2☐XF	7. Age (I	n yrs. last l	Yrs.	Months Day		Min. J	B. Date of Bir (Month, Da uly 3	th ly, Year) 19:	39	9. Birth Coul New	place (State or For http:/ York	reign
and	* II	-	Usual Residence of 10a. State	Decedent 10b. County		10	Oc. City, To	wn or Lo	ation							Od. Inside City Lir	mits
Maryli	1 sho		MD	Montgom	erv		Poto									1 🛱 Yes 2 🗆	
the	28e	Director	10e. Street and Num						10f. Zip Code)			10g. Cit	izen of Wh	at Cou	ntry?	
h with	39 0	2	9421 Gar	rden Cou	rt				2085	4			U.S	S.A.			
deat	E.T.	runeral	11. Marital Status		12. Was Dec	cedent Eve	r in U.S.	13. V	Vas Decedent of Yes, specify Co		gin? (Spec	fy Yes or No		14. Race -	Ameri White,		
036 urs after	- I	2	1 Never Marrie	ed 2 ∑ Married 4 □ Divorced		2∭XNo ive		1	Yes 2 N		i, rueno n	carr, etc.)		Specify:			
5-0	licul.	Completed	(Sneci	15. Decedent's I	Education)	16	a. Deced	ent's Usual Occ and of work dor OO NOT use ret	upation	t of working	,	16b. K	ind of Busi	ness/in	dustry	
21.	Wad	nple	Elementary/Secon	, , , , ,	College ((1-4or 5+)						,					
21 W Bell	it, the	5		(5:	5+		Ir	nform	ation S					Gov		nent	
and and	even d	ו מ	17. Father's Name (First, Middle,					
Z Subject	nark	0	Irving 19a. Informant's Na	Bloc			1	Ob. Mailia	g Address (Stre	Sara			mbec		tete 7:-	O- 4-1	
Z d 2 st	7 Is r traur						1		Garden						ate, Zij	Code)	
5 - and and and and and and and and and and	tem 2		Norton Ha		Husband		20b. Place	of Dispos	ition (Name of		Da	te		ocation - Ci	ity or To	own, State	
Baltimore, Maryland 21215-0036	Mry or II	-	` 4 Donation		rify)	State	Garde		Rememb					ksbu		MD	
Daa	any in		21. Signature of Fur	neral Service Lice	Oto Oto	ttle	nev	Ed 10	Name and Add Ward Sa 91 Rock	ress of Facilit gel Fu ville	neral Pike,	Direc Rockv	tior ille	i, In	c. 208	352	
			23a. Part1. Enter the shock, or hear	ne disease, or con	mplications that	caused the	de de th. De	o not ente	r the mode of d	ying, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between	1
Pro	sician -		Immediate Cause (i	Final					nfarcti							Onset and Death hour	1
/M	ledical		resulting in death)	-			onsequenc		marcu	OII						Hour	
=X8	aminer		Sequentially list con	nditions.	D		duria									5 Years	
035 An	# L	Examiner	Sequentially list con if any, leading to im cause. Enter Unique Cause (Disease or i	mediate living			onsequenc								0.5		
	physician and sthe burial-transit		Cause (Disease or i that initiated events resulting in death) L				melli onsequenc		Tre 2						3	88 years	
68760, flicate be ex	burial	ii m	,		Duerto	(Or as a C	onsaquenc	eroi).									
68760 flicate be	physis the	edical			d.												-
× 6	ding se as		IF FEMALE:		23c. If yes, ou	itcome of a	oregnancy							23d. Date (of dolar	200	
3/3/ B. Bo	should be detached for use a	2	23b. Was decedent in the past 12 1 ☐ Yes 2 ☑	months?	1 ☐ Live	birth 2 [nant at tim	∃Fetal dea e of death		Ectopic pregnar Other (specify)					Month		Day Year	
P.O	d by	Fnysi	9 □Unknown Part II. Other signifi		contributing to a	leath but n	at regulting	in the un	darhina cauca	anyon in Part I		23e Did t	obacco i	ree contrib	uto to t	ne cause of death	
	signe d be of	2	_	tic valv			or resuming	an the un	deriying cause	given in Faiti.	,					ably 4 Unknown	
2 M ords,	hould	erec				313							41			•	
Carol Hab-erman Division of Vital Records, 5 the Hospitel or Attending Physicien: The law requires	2 0 0	Completed	пурє	ertensio	n							24a. Was autop perfo 1 🗆 Yes	rmed?	pride	or to co ath?	psy findings availa mpletion of cause 2 No	of
ii ita	ertific actor.	20	25. Was case referr	red to medical						26. Place	of Death (Check only o					
10 5 jan	his ce	2	examiner? 1 🗆 Yes 2 🗆 I				2 ER/0		3 IN DOM			5 Resid				()	
Hong P	Wher t	ou:	 Manner of Death Natural 	n 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Yo	28b ear)	. Time of Injury	28c. In			d. Describe I	now injur	y occurred			
Sio	tor: /	Certification:	2 Accident 3 Suicide	investigati	he -					Yes 2 1		4 1 tin - //	244	-1.40	. 0	10	
Divi	Direc in by		4 Homicide	determine	d 288. Place	e of Injury ling, etc. (farm, stre	et, factory, offic	.0	28	City or Tox	vn, State	a Number)	or Hura	l Route Number,	
Spitel Bitel	erei liled	۲	29a, Certifier	1 Tr Certifying F	hysicien: To th	e hest of m	v knowlad	go doath	occurred at the	time date as	d place, an	d due to the		and mann	06.00.0	anted.	
L 3 140	completely filled in by the funeral director, page	edical		2 Medical Exa	miner: On the b	pasis of ex	amination a	and/or inv	estigation, in m	y opinion, deal	th occurred	at the time,	date and	place, and	d due to	the cause(s)	
O the	omple	ž Ž	29b. Signature and	title of bertifier					29c. Lice	nse number			29d. Dat	e signed (Month,	Day, Year)	
			12		10 HIL	رجم	1	Tear	D30	8/1/1			31	Inn	101	W. Dr. S	
	30		30. Name and addre	ess of person who	o completed cau	se of dear	h (Kem/23a	i) (Type, I		U 7 7			<u></u>	11100	000	- 25-4	
		(James F	. McMur	rv Jr	M.D.	411	19 R	ockvill	e Pike	. Ste	409.	Rock	ville	. M	D 20852	
	State	·	31. Date filed (Mont	th, Day, Year)	600	Registrar's	Signature	Rose	(i)			3	_ ac. == A)		-		
	Registra	r	APF	₹ 05 20	Sin Sin	w	Jr.	A PROPERTY.									

		1	For State Registrar	State of Ma	aryland / Depa	artment of F			giene Reg. No. 2	0.5	31.61
	Physici	198	1. Decedent's Name (First, Middle, Last		-			2. Date of De Month	Day	3. T Year	ime of Death
	/Medic	al	Robert Thomas He 4a. Facility Name (If not institution, give	ollinger		4b. City, Town, o	Location of Death	April	5 , 2 4c. County o	,	10:20A ^M
	Examin	er	Vantage House	,		Columbia			Howard		
K W	Funeral Director		5. Social Security Number 6. Se 10	x 7. Ag M 2□F	e (In yrs. last birthday) 95 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct. 2		9. Birthplace (S Country) Maryla	State or Foreign nd
	and and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					side City Limits
	the Marylar 28e-f chow	to	Maryland Howard		Columbia					10	☐Yes 2 No
	or 28c	Funeral Director	10e. Street and Number	4. D. 1 A	- 000	10f. Zip Code 21044			10g. Citizen of Wh	nat Country?	
	s 23e	erai	5400 Vantage Poin	12. Was Decedent			ispanic Origin? (Sp	ecify Yes or No		- American Ind	dian,
336	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28e-f ehow event. If a Medical Exeminar mast be meillied all	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	Specify:	Rican, etc.)		, White, etc. White	
2-0	72 hours "natural",	eted	15. Decedent's Ed	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of Bus	iness/Industry	
21215-0036	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5)+)	DO NOT use retired us Office:			Federal Public H	Govern	ment Service
d 2	tiled within al Hygiene. I other than 'vent, It's Me	Be Co	17. Father's Name (First, Middle, Last)		OTATI	S OTTICE.		e (First, Middle	, Maiden Sumame		
Maryland	2 should be and Mental is marked o	To B	Clifford Hyde Hol	linger			Nettie E				
Man	2 sh and is m		19a. Informant's Name/Relationship (7	_		ng Address (Street Vantage					
	s 1 and if Health item 27 other to		Irene C. Hollinge 20a. Method of Disposition	r/wire	20b. Place of Disposemetery, cre			Date 6,	20c. Location - C		
JOIL	ages ant of nt: If it y or o		1 Burial 2 XCremation 3 \(\) 4 Donation 5 Other (Specify		I .	lel Cremat	1 -	005	Odenton,	, Maryl	and
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licen.			2. Name and Addre					
	Physician /Medical Examiner partial transit	dical Examiner	23a. Part1. Enter the disease, or compands, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metastat Due to (or as b	MO1251 P the death. Do not enne. ic Bladder a consequence of): a consequence of):	ter the mode of dyir	, Heckrot	te, P.A	• Clarksv	Appro Inten Onse	MD 2102 oximate val Between et and Death months
.O. Box	of the death certifica by the attending pharched for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	,		23d. Date Mont	of delivery th Day	Year
a	es thet gned b be deta	by Pt	Part II. Other significant conditions of	ontributing to death t	out not resulting in the	underlying cause giv	ren in Part I.		tobacco use contri		
ord	w require been signated should b								A	3 Probably	4 Unknown
Vital Records,	The la ate has page 2	Completed						1 ☐ Yes	psy pr prmed? de 2 2No 1	/ere autopsy fir rior to completi eath? Yes 2 1	
V:E	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	ent 2 ER/Outpatie	ent 3 DOA Oth	26. Place of Dea	th (Check only		ASS r (Specify)Li	isted
Division of	ding h. After fune	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		of 28c. Inju			how injury occurre		VIII
Divis		Certification;	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Place of in	jury - At home, farm, s lc. <i>(Specify)</i>	treet, factory, office			(Street and Numbe wn, State)	r or Rural Rou	te Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medicai			of my knowledge, dea of examination and/or i						ause(s)
_	To the within 2 To the complet	Med	29b. Signature and title of certifier	7 6 / 1		29c. Licen:	se number		29d. Date signed	(Month, Day,	Year)
	->-0		> Ylicholax 1.	Lache let	mis	D385	09		April 5	, 2005	
2			30. Name and address of person who			, Print)				010//	
			Nichulous Koutre	lakos M.D	. 11065 Lit rar's Signature	ttle Patu	xent Pkwy	. Colum	bia, MD	21044	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2005	we do	South)					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2005 Year Robert William April 14, Hane 1215am [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6219-A Quinn Road Frederick Frederick 8. Date of Birth (Month, Day, Year) Apr 15, 1941 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Hours Days Min. 1**X** M 2 □ F 212-38-9334 Director 63 Yrs. Usual Residence of Decedent the Maryland 10a State 10h Counts 10c, City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examinative resided at Maryland Frederick Frederick Completed by Funeral Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6219-A Quinn Road 21701 U.S.A. itams 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 11, Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 is markad othar than Elementary/Secondary (0-12) College (1-4or 5+) Painting Contractor 9 Construction/Remodel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Bernard Hane Pauline 2 Keenev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Hilda E. Hane/Wife 6219-A Quinn Road, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Resthaven Mem Gardens Apr 18,2005 Frederick, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acenses ²², Name and Address of Facility Keeney & Basford P.A. Funeral Home Kotersen M00706 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 106 East Church St, Frederick, Maryland 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC SMALL CELL LUNG CANCER 3 WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consumence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tha Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Box 68760. attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö the 9 Unknown signed by 4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 XNo page certificate 1 ☐ Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft To tha Funaral Di completely filled in 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D56314 April 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Bindu George, M.D., 46-B Thomas Johnson Drive, Frederick, Maryland 21702-4300 APR 2 0 2005 Blown & ORIGINAL 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apr 12, 2005 John Wilbur Himmler 2:45am M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Co. Nursing & Rehab Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov 8, 1914 Birthplace (State or Foreign
 Country) Days Hours 214-05-5115 1**X** M 2□ F 90 Usual Residence of Decedent 10c. City, Town or Location Cumberland Allegany 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 E. Elder Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 21⁄2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer Celanese 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Himmler Barbara Ellen Barnes ^{19a.} Informant's Name/Relationship (Type, Print) Linda Sills daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 64 Boone Street Cumberland MD 21502 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Fairview Christian Cemetery 4/15/2005 Artemas PA ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nargcaffeiis Puitelfal Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Rart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERY CORONARY YRS Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

δ

Completed

Be

10a. State

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exalignment once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Examiner by Physician/Medical Be Completed

by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
ted by Pr	Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 2 ☐
e	25. Was case referred to medical examiner?	26. Place of Death (C	hack only one)
0	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
Cerunc	3 Suicide 6 Could not be determined	289. Place of Injury - At nome, farm, street, factory, office 281.	Location (Street and Number or Rural Route Number, City or Town, State)
Medical Certification:	29a. Certifier 1	vsician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s)
ž	29b Signature and title of certifier	29c License number	29d Date signed (Month Day Year)

APRIL 13TH, 2005

State Registrar

31. Date filed (Month, Pay, Year) APR 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robustiano Barrera M.D Mem. Hosp Med Bldg Cumberland MD 21502 gistrar's Signature

			1 - For Stete Registrar	State of	Maryland /		artmen rtificate			ind M		Reg. No.	2005	13463	
	Physicia	an	Decedent's Name (First, Middle.	. ,							2. Date of Dea Month	Day		3. Time of Death	
	/Medic	al	LIBBY		AFFE		4h Cin.	MARCH 25, 2005 Town, or Location of Death 4c. County					2005 County of Deat	9:45 A ^M	
	Examin		4a. Facility Name (If not institution, SUBURBAN HOSPITA		iDer)		BETH:			r Death			TGOMERY		
Н	Funeral				7. Age (In yrs. last	birthday)	If Under	1 Year	If Under 2		8. Date of Birt (Month, Da		9. Birtl	hplace (State or Foreign	
ь	Director		579-09-6544	1 □ M 2 💢 F	87	Yrs.	Months	Days	Hours	Min.	08/19/1	y, Year) .917		untry) LAND	
	puq *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits	
	Aaryle f sho	٥٠	,	4EDW	,									1 X Yes 2 □ No	
	28e-	rect	MARYLAND MONTGON 10e. Street and Number	IEKI	BETHE	SDA	10f. Zip	Code				10g. Citiz	en of What Co	untry?	
	h with	al D	5225 POOKS HILL	ROAD				2081	4				U.S.A.		
	ems serron	ner	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.				gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.		
36	or It	by Fu	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes If Yes, Give	2 📉 No ∍		1 ☐ Yes 2		Specify:		,			WHITE	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show the Medical Evanifier must be notified at	ed b	15. Decedent	Year or Da		6a. Dece	dent's Usua	I Occupa	ation			16b. Kin	nd of Business/l	Industry	
75	nin 72 In "ne Medir	piet	(Specify only highest Elementary/Secondary (0-12)			(Give life.	kind of wor DO NOT us	k done a e retired	during most)	of worki	ng	100174			
212	giene giene ar tha	Completed	Elementary/Secondary (0-12)	2		HOME	MAKER					OWN	HOME		
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L	.ast)					18. Mothe	r's Name	(First, Middle,	Maiden :	Sumame)		
<u>Y</u> a	Man Men narke	ů	JOSEPH		ISS			(2)	REES		/B / M /		LINE		
Maryland	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationsh										Town, State, Z	up Code)	
ē,	tam 2		STEPHEN H. JAFFE 20a. Method of Disposition	7/ 20M	20b. Place	e of Dispo	sition (Nan	ne of			OMAC, Nate		cation - City or	Town, State	
OE.	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		state	•	natory`or ol D MEM			03/2	7/2005	FAT.T.	S CHURC	H, VIRGINIA	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "netural", or Items 23e or 28e-f show any Injury or other traumatic avant, Ita Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee.							L DIREC			, ,	
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Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 Fetal dea	ath 3	Ectopic pro					2	3d. Date of deli Month	Day Year	
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brd	w require been si should b	ted	PNEUMONIA								1 🗆 \	′es 2X]No 3□Pro	obably 4 Unknown	
Vital Record	as b	Completed	MULTIPLE CEREBRO	OVASCULAR	ACCIDENT	'S					24a. Was autop	sy	prior to c	topsy findings available completion of cause of	
E H		Co										med? 2X No	death? 1 ☐ Yes	2 No	
Zi E	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	npatient 2□ER/			Othe			(Check only o				
of		\vdash 3	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date o	f Injury 28i	Outpatien b. Time of	_	8c. Injury	at Nu		28d. Describe		Other (Spec	aty)	
ion	Attanding I r death. actor: After by the funer	atio	1 Accident 5 ☐ Pending investig	9	h, Day Year)	Injury	М	Work	(? Yes 2 □ N	No					
Division	l or Attanc after death Diractor: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At home	, farm, str	eet, factory	, office		2	8f. Location (S City or Tox		Number or Ru	ral Route Number,	
	urs after rel Dir	O	X												
	To the Hospital or Al within 24 hours after of To the Funerel Dirac completely filled in by	edical	29a. Certifier 1 \(\times\) Certifying (Check only 2 \(\times\) Medical E one)	g Physician: To the Examiner: On the ba	sis of examination	dge, death and/or in	n occurred a vestigation,	at the tim in my op	ie, date and pinion, deat	d place, a h occurre	and due to the o ad at the time,	date and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier		or stated.		29c	. License	number			29d. Date	signed (Month	n, Day, Year)	
	->-0		1////	()/			6	2347			N	1ARCH	25, 20	005	
	3		30. Name and a de ss of person v	who completed cause	e of death (Item 23	la) (Type,	1	0					5.51.5-7.5-1	*	
			MARJORIE DANNIS					ROA	D, BE	THES	DA, MD	2081	4		
8	Sta Registr		31. Date filed (Month, Day, Year) APR 05	2005	egistrar's Signature	Ap	all.								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#8. PerFH PCC4-7-05 cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Physician DORIS **JANOFSKY** F. 30, 4:40 a M MARCH 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1921 | 9. Birthplace (State or Foreign | Months | Days | Hours | Min. | (Month, Day, Year) | 1921 | 9. Birthplace (State or Foreign | Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 XF 219-01-4669 83 Director MAY 31, 1912 WASHINGTON DC Usual Residence of Decedent with the Maryland Show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "neturel", or items 23a or 28a-f show the Medical Examination wat be notified at Director 1 ☐ Yes 2 X No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3912 BEL PRE ROAD 20906 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER BAKERY mit. Pages 1 and 2 should be filed w pertment of Health and Mental Hygier portant: If item 27 is marked other thy injury or other treumatic event, In. 12 should be filed whand Mental Hygiel 7 is marked other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JULIUS FINE ETTA ROSENTHAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE COHEN - DAUGHTER 10417 ROYAL ROAD SILVER SPRING MARYLAND 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State KING DAVID 4/1/2005 FALLS CHURCH, VIRGINIA `4 ☐Donation 5 ☐ Other (Specify) GARDENS ame and Address of Facility MEMORIAL permit.
Deportr
Imports
any nji 21. Sign prept Furgist 3 NATIONAL FUNERAL HOME 7482 LEE HIGHWAY FALLS CHURCH, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Due to (or as a consequence of): Cardiac minutes /Medical Examiner strointestina To (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 🗆 No 1 Yes 2 **2** No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No Other: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident after death. Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL TAKOMA PARK Md. 20912 7610 AVE. 1HOMAS 31. Date filed (Month, Day, Year) Registrar's Signature State APR 0 7 2005 Registrar

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			For State	State of M	arylar	•		Health and	mentai Hy	gien	ก กร	1341	55
			1 - State Registrar			Ce	rtificate of	Death		Reg. No	.000	1 0 4	
	Physici	an	Decedent's Name (First, Middle	, Last)					2. Date of De Month	aath Da	y Year	3. Time of	f Death
	/Medic		Edith Marian Jo	·					April	10,	2005	7:30	A^{M}
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o	or Location of Deat	h	40			
			8619 Pinecliff				Frederic				ederick		
	Funeral		5. Social Security Number	6. Sex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year,	9. Birth	place (State ontry)	or Foreign
	Director		220-16-5662		79	Yrs.			Dec. 1	1, 1	925 Mary	land	
and	* _		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside C	ity Limits
Aaryl	of a pa	ō		. 1								1 🗆 Yes	-
the N	28a-	Directo	Maryland Freder:	ıck	Fred	erick	10f. Zip Code	_	T	10a C	itizen of What Cour	atas?	
with	a or			D 1							M2011 OI WITAL COU	itiy:	
.UU30 hours after death with the Maryland	1a 23	Funeral	8619 Pinecliff 1	12. Was Decedent	Ever in II	S 13	21704	Hispanic Origin? /5		USA	14. Race - Americ	can Indian	
terd	re le	5	1 ☐ Never Married 2 📉 Marr	Armed Forces?	•	.0.	If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puer	to Rican, etc.)		Black, White,		
JSC Irs af	0,1	b	3 ☐ Widowed 4 ☐ Divorced	If Yes Give		ļ	1⊡Yes 2∭X No	Specify:			Specify: Whit	- 0	
Z 1 Z 1 3-0036 d within 72 hours aff	a stura		15. Decedent	t's Education		16a. Dece	dent's Usual Occup	pation		16b. F	(ind of Business/In		
. is	프랑	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4or)	E ()	(Give	kind of work done DO NOT use retire	during most of wo	rking			,	
N T N	r tha	E	12	College (1-401)	0+)	homem	aker			own	home		
D #	othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maidei	n Sumame)		
yland ould be file	lenta Ked ic e	ToB	Thomas Francis 1	Moran				Mary Kat	hleen P	orte	r		
Sport Sport	N DU	_	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	ng Address (Street				or Town, State, Zip	Code)	
Maa nd 2 st	alth a 27 to		Frederick C. Joy	vce, husband		8619	Pineclift	E Drive,	Frederi	ck.	MD 2170	4	
S .	f Hei Item othe	1	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other pla		Date		ocation - City or To		
288 B	ento nt: If ny or	100	1 X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S)						4/2005	Mt.	Savage,	Marv1	and
Saltimore, permit. Pages 1 av	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service		1			-3			sford Fu		
n a	Deparimpor		Huan M.	Kura	мΩ						rick, MD	2170	
	-		23a. Part1. Enter the disease, or shock, or leart failure. List	complications that cause							LICK, TID	Approximat	е
-			Immediate Cause (Final	_			/					Interval Bet Onset and	
	ysician Medical		disease or condition resulting in death)	a. Chron		MANTEL	y Dis	ease				yrs	
Ex	aminer			200 10 (01 40	a compa	dorido orj.							
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be executed	n an ial-tr	Examiner	resulting in death) Last	Due to (or as	a conseq	uence of):							
	hysician and the burial-transit	cal	l l	d									
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BOX	andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7c				23d. Date of delive	ery	
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ر ا	by th ache	hys	9 Unknown	9□ Unknown									
ords, P.O	been signed by the attending ph should be detached for use as th	by P	Part II. Dther significant condition	ons contributing to death b	ut not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did 1	obacco	use contribute to the	ne cause of d	leath?
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ຽ ≥	s bee	Completed	Chronic	Renal T)ica.	a (e			24a. Was		24b. Were auto	psy findings	available
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	tifical tor, p	a)	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes ath (Check only o	2 🔼 No	1 ☐ Yes	2 L NO	
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din g	r: Afr e fun	atlo	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig		y rear)	Injury		rk≀ Yes 2∐No					
UIVISION or Attending	ector by th	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be 28e. Place of Inj	ury - At h	ome, farm, str	eet, factory, office				nd Number or Rura	I Route Num	ber,
5 5	d in l	Certification:	4 Hottlicide	building, et	c. (Specif	у)			City or To	wn, Stati	θ)		
spit	hours inera y fille		29a. Certifier 1 X Certifyin	g Physician: To the best	of my kno	wiedge, deat	n occurred at the ti	me, date and place	e, and due to the	cause(s) and manner as s	tated.	
De Ho	within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2.	edical	(Check only 2 Medical one)	Examiner: On the basis o and manner st	f examina	ition and/or in	vestigation, in my o	opinion, death occu	irred at the time,	date an	d place, and due to	the cause(s)
Toth	withii To th	Me	29b. Signature and title of certifier	r			29c. Licens				ite signed (Month,		
		15	1-1	M Wil			Dod	47679		Apri	11 12,2	005	
	q		30. Name and address of person	who completed cause of c	leath (Iten	n 23a) (Type,	Print)	· ·					
	9		Francis Greun	C	600	1 501	aver Cr	+ #10	3, Fre	dei	il 12,2	D 217	03
	Sta	ite	31. Date filed (Month, Day, Year)	32. Paristr	ar's Signa	iture			,				
	Registr	rar	APR 20	2005	40 .	KA	and a						

		•	For State	State of Maryla	,	artment of F			200	5 131.66
			Registrar 1. Decedent's Name (First, Middle, Lasi	<u> </u>		runoato or i	Journ	2. Date of Deat	eg. No. UU th	3. Time of Death
F	hysici		MILDRED R.	KESHNER				Month MARCH 2	•	11:30 P M
X 100	Medio/ Examir		4a. Fecility Name (If not institution, give			4b. City, Town, o	Location of Deat		4c. County of	
			COLLINGSWOOD NURS	ING HOME		ROCKV	ILLE		MONTGOM	IERY
Fo	uneral		5. Social Security Number 6. Se	x 7. Age (In yrs	-				Year) 9	Birthplace (State or Foreign Country)
Di	rector		053-30-384/]M 2Å F	94 Yrs.			FEB. 25,	1911 N	IEW YORK
and	* -		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
Mary	fed at	ō	MARYLAND MONTGOME	POC	KVILLE					1X Yes 2 □ No
the	7.28a	Director	10e. Street and Number	KI KUC.	KATEE	10f. Zip Code		1	0g. Citizen of Wha	at Country?
death with the Maryland	38 o		299 HURLEY AVENUE			20850			U.S.	Α.
deat	E E	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No-	14. Race -	American Indian, White, etc.
Within 72 hours after ene.	ir than "natural", or items 23a or 28a-1 shov the Medical Examiner must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🕅 No	Specify:		Specify:	
hours af	le E	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	150 Days	adaptio Havel Occur	ation			WHITE
0 72 u	- una	Completed	15. Decedent's Edi (Specify only highest grad	le completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of wo		16b. Kind of Busir	ness/industry
with A	H M	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	OWNER	3	,		RETAIL	
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arylar should b	marked cumatic even	70 E	MENDEL	ROSENBLUM			PESHE		GORNI	TSKY
2 sho	e ma		19a. Informant's Name/Relationship (T		19b. Mail	ing Address (Street	and Number or R	ural Route Number	, City or Town, Sta	ate, Zip Code)
and and lealth	m 27 her tr		SHARON GOBEL/DAUGH			SILVER KIN	IG LN., 1			
Pages 1	Og H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X	Removal from State	cemetery, cre	matory or other plac			20c. Location - Cit	
SAILTIMOR Sermit. Pages Department of	Important: If itsm 27 is merke any injury or other traumatic once.		* 4 □Donation 5 □Other (Specify, 21. Signature of Funeral Service Licens		AR OF 1	DAVID CEM	ETERY 03	/31/2005	N. LAUDE	RDALE, FL
Departs	any ir		→ amanda	Ludeurg	7 11	2. Name and Addre ANZANSKY-(L70 ROCKV]	OLDBERG LLE PIK	MEMORIAL E, ROCKVI	CHAPELS	, INC. 20852
	12		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the de	ath. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between
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pet	nsit	ulu ulu	Cause (Disease or injury	c HYPERTENSIO						
J, execu	n and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or as a conse						
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OX O	signed by the attending p d be detached for use as	/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy				23d. Date of	of delivery
death cer	atter d for u	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	tal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			Month	•
that the	by the	hys	9 Dunknown	9□ Unknown						
S, T	gned se del	by P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the	anderlying cause giv	en in Part I.			ute to the cause of death?
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§ (b	S CA	ompleted						24a. Was a autops	v pric	re autopsy findings available or to completion of cause of
T ed :	pag	Con						1 Yes	med? dea 2A No 1□	itn?]Yes 2□ No
OT VITAL	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot all post Oth		ath (Check only on		
5 A	this ald	2	1 Yes 2 No 27. Manner of Death	1 L Inpatient 2L	ER/Outpatie	nt 3 DOA	4AL Nursing i	Home 5 Reside	ow injury occurred	
ding	After the funeral	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No		, , , , , , , , , , , , , , , ,	
DIVISION of all or Attending F	octor by the	ertification;	3 Suicide 6 Could not be	28e. Place of injury - At I	home, larm, st	reet, lactory, office				or Rural Route Number,
lal or s afte	od in t	Cert	4 Homicide	building, etc. (Spec	iny)			City or Town	i, Siale)	
Hospit 24 hours	To the Funeral Director: A completely filled in by the fu	edica! (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kriner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred at the time time time to the time time to the time to the time time to the time time to the time time time time time time time tim	ne, date and place pinion, death occ	e, and due to the courred at the time, d	ause(s) and mannate and place, and	er as stated. I due to the cause(s)
To this within	To the comple	Mec	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (/	Month, Dey, Year)
_			hoch	MD.		D301	32	M	ARCH 28,	2005
	V		30. Name and address of person who of RITA GHOSH, M.D.,	,						
E.	Sta	ate	31. Date Hed (Month, Day, Year)				ILLE, MI	20852		
₩ 190 &	Regist		APR 05 20	32 Registrar's Sign	K Apr	uli)				

Ronald Preston LANG Baltimore, Maryland 21215-0036

			_ For		at in Black In	artment of H	lealth and N	•	•	gible.		
			Registrar 1. Decedent's Name (First, Middle, Last	,	ang	rtificate of	Death	2. Date of Dea Month March	onth Day Year			
}			Doctors Hospit 5. Social Security Number 6. Se	a1 × 7. Age	ə (İn yrs. last birthday)	4b. City, Town, o Lanh If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt	Prin	ty of Death Ce George's 9. Birthplace (State or Forei		
			Usual Residence of Decedent	X M 2□F	63 Yrs.		Hours Min.	June 1,	1941	Virginia		
the Maryla	28a-f show	ector	Md. P.G.		10c. City, Town or Lo	ttsville			40 - Oili	10d. Inside City Limit		
žį.	3a or	I Dir				10f. Zip Code 207	01		10g. Citizen of What Country?			
036 ours after death	rel', or Items 2 Examiner mus	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	to	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			No- 14. Race - American Indian, Black, White, etc. Specify: White			
2121 ad within	ygiene. ier than "netur t, tre Madical	Completed	(Specify only highest grad	le completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired None	during most of worl		N	Business/Industry		
yland ylid be fil	Mental H arked oth atic even	To Be		ang			18. Mother's Nam	Rost		nme)		
The state of Market The state The st	9115 20b. Place of Dispo cometery, cref Chambers	Marlboro sition (Name of natory or other place Cremator	Pike, Lo	t67 Uppe Date	per Marlboro, Md. 20772 20c. Location - City or Town, State Riverdale, Md. Crematorium, P.A.							
1	Medical		Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not ent	301 Cleve er the mode of dyin				Approximate Interval Between Onset and Death		
876U, cate be executed			resulting in death) Last	c. Due to (or as a	a consequence of:	ita	Topul	iacene	ži,			
O. BOX 6 the death certific	/ the attending p	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth : 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year		
rds, P.	an signed by	by	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	1	bacco use cor	ntribute to the cause of death?		
The law re	cate has ber page 2 sho	Complet						24a. Was a autop perfor	sy	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
ion anding	раth. pr: After this ne funeral dii	ToB	examiner? 1 Yes 2 No F 27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	1 Unpatier		28c. Injury Work	4 Nursing H	th Check on or ome 5 Resid 28d. Describe h	ence 6 🗆 Ot			
UIVIS	irs after di rel Directi led in by t	Certific	4 Homicide determined	building, etc				City or Tow	n, State)	ber or Rural Route Number,		
the Hospi	the Funei tpletely fill		one)	ner: On the basis of	examination and/or inv	restigation, in my op	pinion, death occur	red at the time, o	late and place	, and due to the cause(s)		
To	with To Com			leted cause of de	eath (Item 23a) (Type.	29c. License		1		31/05		
			575 Main S	street,	wite 35	Layi	·el, 111	0 2070	07			

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who leted cause of death (Item 23a) (Type, Print)

575 Main Street Suite 351,

31. Date filed (Month, Day, Year)

APR 0 5 2005

32 Registrar's Signature

Nette LAnder 227-38 6083.
Baltimore, Maryland 21215-0036

			For State Registrar	State of M	Maryland / Dep Co	partment of F		-	giene Reg. No. 2	nns	101	
			Decedent's Name (First, Middle	, Last)				2. Date of De	ath	UUI	3. Time of D	eath O
	Physici		Nellie	McCready		Landon		Month	Day	Year	1950	м
	/Medi Examir	_	4a. Facility Name (If not institution				r Location of Deat			inty of Death		
			Peninsula lea	noal Medic	al lenter	So	lishurd	,	IN	icom	110	
	Funeral				Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Ars Hours Min.		lh V Voorl		place (State or a	Foreign
	Director		227-38-6083	1 □ M 2 🔀 F	71 Yrs.	Worth's Days	Tiours Willi.	August 1	, 1933	Virg		
	p a		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d Incide Oite	Limite
	sho	2	Toa. State			Location					10d. Inside City 1 X Yes 2	
	Ne N	Director	Virginia Accomac	:k	Tangier	404 7 0 4			40. 03.	-4310 - 40		
	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show dical Examinet must be notified at		10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?	
	s 23	Funeral	4379 Long Bridge	e Road 12. Was Deceder	t Everial I S 13	23440 3. Was Decedent of H	ionania Osiaina /G	Sansifu Van an Na	USA	Race - Ameri	oon Indian	
	Item	Ľ.	1 Never Married Married Marri	Armed Force	S?	If Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)	- 14.	Black, White,		
336	Irs af	by F	3 Widowed 4 Divorced	ed 1 Tes 27 If Yes, Give Year or Dates		1☐ Yes 21 No	Specify:		Spe	ecity: Whi	te	
1215-0036	2 hot	ted	15. Decedent	s Education		cedent's Usual Occup			16b. Kind o	f Business/In	dustry	
215	within 7. ene. than "n	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4o	life	ve kind of work done of DO NOT use retired	during most of wo f)	rking				
217	d with giene.	mo	10			maker			Domes	tic		
	e filled at Hygi other vent, I	Bec	17. Father's Name (First, Middle, I	_ast)			18. Mother's Na	me (First, Middle,				
lar	should be Ind Mental Is marked o	To E	Charles	McCr	eady		Lucy -	Cro	ockett			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28a-1 show other traumatic event, tre Modical Examirer rust it is notified at	Γ.	19a. Informant's Name/Relationsh	ip (Type, Print)		iling Address (Street	and Number or Ri	ural Route Numbe	er, City or To	wn, State. Zij	Code)	-
	1 and 2 Health a em 27 is		O. Ross Landon	- Husband	4379	Long Brid	dge Road,	PO Box	63 ,	Tangie	er, VA 2	23440
ore	of He of He fitem		20a. Method of Disposition	0	comotony ci	position (Name of rematory or other place	e)	Date	20c. Location	on - City or T	own, State	
Ĕ	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp		A	ent Church C	,	6/2005	Tangie	er, Vi	ginia	
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr <u>once</u> .		21. Signature of Funeral Service I	icensee	Q. W	22. Name and Addre	neral Ho	ome, 2504	46 Pari	ksley	Road	
			23a Part1. Enter the disease, or	Willes	P	arksley, V	<i>l</i> irginia	_24321			Approximate	
			shock, or heart failure. List of the shock is the shock of heart failure.	only one cause on each	Jine.	0 1 M	g, odor do odrala	o or roopiratory ar	1031,		Interval Betwee Onset and De	
	Physician /Medical		disease or condition resulting in death)	a	rolice ((V/Ry/An	w				20 m	h.
	Examiner			Due to (or a	is a consequence of):	1					2-1	
н		ē	Sequentially list conditions,	b. Due to (or	Sa consequence of):	···					29	25
	ted nsit	딑	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	//	,					-	(1)	
	al-tra	Examin	that initiated events resulting in death) Last	c Due to (or a	is a consequence of);							
8760	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal E								1		
687	ficate phy: s the	edlo		0.								WHE T
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d	Date of delive	env	
ğ	death atte	clai	in the past 12 months?			☐Ectopic pregnancy ☐ Other (specify)				Month	Day Ye	ar
o.	tt the de by the tached	lys	9 Unknown	9□ Unknown								
σ.	es that igned b	by PI	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use c	ontribute to t	he cause of dea	ath?
rds	quire; n sign	Q D	Cancer	of Use.	my black	lu se	X	1 🗆 Y	′es 2□No	3 Prot	ably 4 Dun	Known
Records,	w require s been si should b	Completed		1 Nox	14			24a. Was	an 24	b. Were auto	psv findings av	ailable
Be	he lav e has age 2 :	ЩC		7(204	5/023			autop	rmed?	death?	psy findings av mpletion of cau	se of
		Ö	25. Was case referred to medical				36 Place of Do		2 No	1 🗆 Yes	2 NO	
5	Physicien: this certific ral director,	o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	tient 2 ER/Outpati	ent 3 DOA Othe	25	ath (Check only o		Other (Consider		
		 	27. Manner of Death	28a. Date of In (Month, D		of 28c. Injury		28d. Describe h			у)	
Division	ding P th. : After funera	Certification:	1 Natural 5 Pending 2 Accident investig		Day Year) Injury		<br Yes 2 □ No					
/isi	Attendii r death. sctor: A sy the fu	flca	3 ☐ Suicide 6 ☐ Could n	ned 286. Place of I	njury - At home, farm,	street, factory, office		28f. Location (S	Street and Nu	mber or Rura	I Route Numbe	ЭГ.
ā	after after Direct din b	erti	4 Homicide	building,	etc. (Specify)			City or Tow	m, State)			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying	g Physician: To the bes	st of my k <i>n</i> owledge, dea	ath occurred at the tim	ne, date and place	and due to the o	cause(s) and	manner as s	tated.	
	as Hc	Medical	(Check only 2 Medical E	examiner: On the basis and manner:	of examination and/or	investigation, in my op	oinion, death occu	irred at the time,	date and place	e, and due to	the cause(s)	
	To the within To the Comp	Me	29b. Signature and title of certifier	. //	/	29c. License	number		29d. Date sig	ned (Month.	Day, Year)	
)			P. A	S. 11	21 11 1	10-	20080		4	3/10		
			30. Name and address of person v	vho completed cause of	death (Item 23a) (Type	e, Print)	S.7.30	/	/_/	100		
			Roux	CHAIL	. 121-1	outh Divi	era St	. Sols		402	1800	
	Sta	ite	31. Date filed (Month, Day, Year)		trar's Signature	1. 1.			7 /		-	
	Registi	ar	APR -	5 2005	steen st.	1930		_				

			1 - For State Registrer	State of Maryla	nd / Depa		Health and M	1ental Hygi	ene 	131.60	
	Physici		1. Decedent's Name (First, Middle, Last) Robert C. Linthic	um				2. Date of Death Month Mar. 29	Day Year	3. Time of Death 4:25 p M	
	/Medi Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of Death		
	Funeral Director		462 Arundel Beach 5. Social Security Number 6. Sex 218–10–2421		s. last birthday) Yrs.	Se If Under 1 Year Months Days	everna Par If Under 24 Hrs. Hours Min.	k 8. Date of Birth (Month, Day, Jun. 20,	Year) 9. Bi	Arundel inthplace (State or Foreign country) MD	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits	
	Maryl a-f sho	tor	MD Anne Aru		,,		a Park			1 □ Yes 2 🙀 No	
	with the	Direc	10e. Street and Number 462 Arundel Beach	Road		10f. Zip Code	1146	10	g. Citizen of What C	country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28a-f show shi injury or other treumatic event, the Marical Examinate institution at once.	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
00-6121	rithin 72 hourne. ne. hen "netural e Mudicel Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work d)	ing 1	6b. Kind of Business Govern		
Maryland 21215-0036	uld be filed w Mental Hygier rked other ti tic event, the	To Be Cor	17. Father's Name (First, Middle, Last) Hezekiah Linthicu	4 m		Civil En	=	e (First, Middle, Mi uldoon			
	and 2 should lealth and Men n 27 Is marke		19a. Informant's Name/Relationship (Type Robert C. Linthic						City or Town, State,		
Baltimore,	Pages 1 and ment of Heament: If item		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Ro • 4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place en Cemete	I TOL.	4	oc. Location - City o		
Balt	permit. Departi Import eny inj		21. Signature of Funeral Service License	1/4	B 4	Name and Address Arranco 95 Gov.	& Sons, P Ritchie H	.A. Sever	ma Park I ma Park,	Funeral Home MD 21146	
	Physician /Medical Examiner		23a. Pant 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the dea e cause on each line. Due to (or as a conse	ath. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death	
,/eu,	te be executed ysician and e burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	<u> </u>						
O. Box 62	the death certifically the attending phiched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fei 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy	1		23d. Date of de Month	slivery Day Year	
7	The law requires that the de ste has been signed by the a page 2 should be detached	by	Part II. Dther significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	1/	o the cause of death?	
II Kecoras,	The lay ate has bage 2	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of	
or vital	sicien certifi rector	Be c	25. Was case referred to medical examiner?	ospital:	7500	Oth	00	(Check only one)			
lon or	ing i	atlon; To	1 Yes 22 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at	me 5 Hesiden 28d. Lescribe how	ce 6 Other (Sperinjury occurred	ecify)	
DIVISION	tet or Attendi s after death. el Director: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre ify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,	
	To the Hospitet or Att within 24 hours after d To the Funerel Direct completely filled in by	Medical (29a. Certifier (Check only one) 2 Medicel Exemin	icien: To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)	
	Tot. withi Totl	W	29b. Signature and title of certifier Canux W	erny nu	2	29c. Licens	2830	1	1. Date signed (Mon	0 1705	
			30. Name and address of person who con Ilanine weight	mpleted cause of death (Ite	em 23a) (Type, F	Print)	oad # 3	20 Ann	upalis N	10 21401	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 20	32. P distrar's Sign	nature	books					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APEIL **Physician** 5:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Director 577-14-2898 April 13, 1919 85 Wash. D. C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits NO Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? al Hygiene. other than "natural", or Items 23a or vent, the Medical Examiner must be 6105 Montrose Road 20852 U. S. _A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Secretary U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Department of Health and Mental Himportant: If Item 27 is marked oth any injury or other traumatic even once. Morris Mickelson Bertha Rothman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 20906 19a. Informant's Name/Relationship (Type, Print) David E. Zarin - Cousin 2900 N. Leisure World Blvd., # 304, Silver Spring 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4/5/2005 Mount Lebanon * 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland permit. 21. Signature of Funeral Service L 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. Donald ·1091 Rockville Pike, Rockville, Maryland _20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 by Physiclan/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No O 9 Unknown 9 Unknown ģ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 Yes 217 No 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 3□ DOA 2 ☐ ER/Outpatient this luneral 27. Manna of Death 28c. Injury at Work? Certification; 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Linatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature Braffile of regitie Kalazny, M 29d. Date signed (Month, Dey, Year) 30. Name CKVILLE, MD 2085 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ester 9, Marie Mann April 2005 /Medical 11:50pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Goodwill Mennonite Home Inc Grantsville Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2□ E Hours Months Days Yrs. Director 579-20-5871 86 20 12-20-1918 Pennsylvania Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ :- any injury or other traumetic averages. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 255 Tomar Drive 21550 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2**XX**0 If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ If Yes, Give Year or Dates: White 3 Widowed 4 □ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher/Bookkeeper School/Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Frank Ryan Effie Violet Everly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. McCullough 255 Tomar Dr., Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Steele Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/12/2005 Friendsville,MD 22. Name and Address of Facility Carl R. Spear Funeral Home RR 5, Box 1, Bruceton Mills, WV 26525 23a. Part1. Enter the osease, or comshock, or heart failure. List only itions that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death **Physician** END STAGE /Medical Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE LUNG Examiner Examiner BPIRATION or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last FIBRILL P.O. Box 68760. Completed by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? CANCER, HYPERTENTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? OWER GASTROINTESTINAL BLEEDING. MYOPATHY STEROID 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTED 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 PNatural after death.

Director: Af id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atter within 24 hours after des To tha Funaral Director completely filled in by th 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Grantsville, MB 21536 NAWAB 32 Corporate 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2005 Registrar

			For State Registrar	State of Ma		partment of H ertificate of I		ental Hygier		13472
			Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Death
	Physicia		Carl Ja	mes	Morela	nd		April 7	2005	7:35 P M
>	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		c. County of Death	1
ı			Garrett County M	emorial Hos	pital	C	akland		Garr	ett
	Funeral		Social Security Number 6. S	EN OUL	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	lace (State or Foreign
	Director		219016696	MW SOL	90 Yrs.			Nov. 25,		t Virginia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			1	0d. Inside City Limits
	Mary	ğ	WV Gra	nt		Mt. St	orm			1 ☐ Yes 2 ☑ No
	1 the	Director	10e. Street and Number			10f. Zip Code	2	10g. (Citizen of What Cour	itry?
	h with		HC 76, Box 108				26739		USA	
	deat	Funeral	11. Marital Status	12. Was Decedent Ex Armed Forces?	ver in U.S. 13	B. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 le marked other than "natural; or Items 23a or 28e-f show any Injury or other treumatic event, the Marylani Examination to other treumatic event, the Marylani Examination to other treumatic event.	by Fu	1 Never Married 2 Married	1 ☐Yes 2 ☐ No If Yes, Give	WW II	1 ☐ Yes 2 ☑ No	Specify:	ribari, oto.,		hite
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212	with Jiene.	Шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Coal Min	ner		Coal Min	ing
פַ	othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	en Sumame)	
Maryland 2121	uld bu Vienta Vienta Irked	ToE	Dorsey Le	o Mo	reland		Ina	Cather	ine The	ompson
ar	2 sho and I le ma		19a. Informant's Name/Relationship (iling Address (Street			y or Town, State, Zip	Code)
≥ ′`	and salth m 27		Richard Moreland	/Son		Box 88, M				
Baltimore,	ges 1 t of H If ite or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, ci	position (Name of rematory or other place	ı		Location - City or To	wn, State
Ē	t. Pa rtmen rtent: rjury		' 4 □Donation 5 □ Other (Special		Mt. Sto	rm Cemeter	*	and the second second	. Storm, I	
Ba	Depa Impo any l		21. Signature of Funeral Service Lice	Cales VV		22. Name and Addre Stewart Fu			S. Second land, Md.	
			23a. Part1. Enter the disease, or com	plications that caused t	he death. Do not e				Land, Mu.	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on ear line	9. 1	hyocave	1/ 1 1			Interval Botween Onset and Death
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80,	ificate be executed g physician and as the burial-transit	E E	1930king in death) Last	Due to (or as a	consequence of):					
68760,	ficate I physics the b	edical		_ d.						
-	- O m	/Me	IF FEMALE:	23c. If yes, outcome of	f pregnancy				23d. Date of delive	201
Box	eath etten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death	B Ectopic pregnancy	1		Month Month	Day Year
Р. О.	the d	hysi	1 Yes 2 No 9 Unknown	9 Unknown						
	w requires that the death certifuces signed by the ettending should be detached for use as	by Physician/M	Part II. Other significant conditions	ontributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
ğ	en sig	edt)(a	nexes	1			1 ☐ Yes	2□No 3□Prob	ably 4 Anknown
Vital Records,	law re as be 2 sho	Completed	(-I	13/660	ling			24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
m —	The ate h	E C			J.			performed	death?	
/ita	clan: ertific ector,	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
5	hysle this cal	၉	1 ☐ Yes 2 No	Hospital: 1 Theatier			4 🗀 Nursing Ho	me 5 Residence		1)
N C	Attending Physician: The law requires that the death cert cleath. ector: Atter this certificate hes been signed by the ettendinby the funeral director, page 2 should be detached for use it	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	/ Wor	k?	28d. Describe how in	jury occurred	
Si	death death stor: / the	Icat	2 Accident investigation 3 Suicide 6 Could not be	OB Class of Injur	rv - At home farm	street, factory, office	Yes 2 □No	28f. Location (Street	and Number or Rura	I Route Number
Division of	P # 12 E	Certification:	4 Homicide determined	building, etc.	(Specify)	street, ractory, office		City or Town, St		Though Hambor
	Hospital or 24 hours afte Funeral Dir stely filled in I		29a. Certifier 12 Sertifying P	nysician: To the best o	f my knowledge, de	ath occurred at the tir	me, date and place,	and due to the cause	(s) and manner as s	tated.
	ne Ho n 24 l	edical	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination and/or	investigation, in my o	pinion, death occurr	ed at the time, date a	and place, and due to	the cause(s)
	To the within 2. To the complet	ž	29b. Signature and title of certifier	///		29c. Licens		29d. I	Date signed (Month,	Day, Year)
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4	TVH		30. Name and address of person who				0.11	1 1/1 0	1550	
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	Sta Regist		31. Date filed (Month Pay, Year)	1005 SZ. ASSISTA		Lord Marie				
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			For	State of N	/larylan	-				Mental Hy	giene	000	10170
			1 - State Registrar 1. Decedent's Name (First, Middentification)	Un I and		Ce	rtifica	te of L	Death	2. Date of De	Reg. No	CUU.	134/3
	Physici	an	Jack Emerson							Month	Day		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	on, give street and numbe	nr)		4b. City	, Town, or	Location of Dea	March	31 4c.	2005 County of Deat	11071
	LXdiiiii	iei	Anne Arundel	Medical Cen	ter			А	nnapolis	5		Anne	e Arundel
	Funeral		5. Social Security Number	6. Sex 7. / 1%CMM 2□ F		last birthday)	If Unde Months	r 1 Year		8. Date of Bi	th ay, Year)	9. Birt	thplace (State or Foreign buntry)
ı.	Director		220-16-5036 Usual Residence of Decedent		80	Yrs.				Jan. 1	3, 19		aryland
	yland		10a. State 10b. Count		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	e Mar le-f si	ctor	Maryland Anne	e Arundel				A	nnapolis	5			1 ☑ Yes 2 ☐ No
	with th	Director	10e. Street and Number 1302 President	Ctroot			10f. Z	p Code	21.402		10g. Citiz	en of What Co	
	eath v	Funeral	1302 FIESIGEII	12. Was Deceder	nt Ever in U	S 13	Was Dece	dent of Hi	21403	Specify Yes or N	n 1 1	4. Race - Ame	S.A.
٥	or iten		1 ☐ Never Married 2 ☐ Ma	rried Armed Force:	s?					Specify Yes or No to Rican, etc.)		Black, Whit	
മടവവ-മ	ural', c	d by	3℃Widowed 4 □ Divorce	d If Yes, Give Year or Dates	1943	-45	1 🗆 Yes	21 X N0	Specify:			Specify:	White
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Mar	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other treumetic evonce.	16	19a. Informant's Name/Relation Donna Howard							ural Route Numb Edgewate	-		· ·
a)	Healt Healt tem 2		20a. Method of Disposition		20b. F	Place of Dispo				Date		cation - City or	
Ē	Pages ent of nt: If i		1 🔀 Burial 2 □ Cremation 1 □ Donation 5 □ Other (rdens 4/	4/2005	Ann	apolis,	Maryland
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			23a. Part1. Enter the disease, of shock, or heart failure. Lis	t only one cause on each	line.				g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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X Q Q	leath certifica attending ph d for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐Live birth			∃Ectopic p	regnancy			2	3d. Date of del	,
	ne dea the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown		eath 5	Other (s	pecify)				Month	Day Year
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VItal	Physicien: this certific ral director,	Be	25. Was case referred to medic examiner?	Hospital:	- 72			Othe	\C	ath (Check only			
ō	y sic	on: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Inpa 28a. Date of Ir (Month, L		ÆR/Outpatier 28b. Time o		28c. Injury Work	4 🗀 Idaisiild i	lome 5 ☐ Res 28d. Describe			cify)
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	To the Hospitel or Attending PI within 24 hours after death. To the Funerel Director: After th completely litted in by the funera	edicai		ing Physician: To the bear I Examiner: On the basis and manner	of examina	tion and/or in	vestigation	at the tim	e, date and plac pinion, death occ	e, and due to the urred at the time,	date and	and manner as place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certif	er M	/	10	29	c. License	number		29d. Date	signed (Monti	h, Day, Year)
			1 (Trego	up ///	Jef	hel		D 1	4758		Apı	ril 2,	2005
			30. Name and address perso										
	Sta	te	Gregory Mitche 31. Date filed (Month, Day, Yea	11, MD 2001	Medi strar's Signa	.cal Pa	ırkwa	y Ar	mapolis	, Maryla	nd 2	21401	
•	Registi		APR (4 2005	alexe.	A. A	15004						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No.. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LINDA Κ. MURPHY-FLANAGAN /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HICOMED SA43bung PENINSULA REGIONAL MEDICAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth SEPT 17, 1965 5. Social Security Number **Funeral** DELAWARE 1 M 2 F 221-62-9790 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f shov other traumatic avant, the Medical Examiners sust be notified at 1 Yes 2 No WICOMICO SALISBURY Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 IISA 21804 30500 BENNETT RD. Itams 23a Completed by Funeral 12. Was Decedent Ever/in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CREDIT CARD COMPANY CREDIT REPORT RESEARCHER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fill and Mental H EDNA LONGFELLOW JAMES G. MURPHY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30500 BENNETT RD., SALISBURY, MD 21804 Health Itam 27 I JAMES FLANAGAN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ita any Injury or ot 1 XBurial 2 Cremation 3 Removal from State ODD FELLOWS CEMETERY 4-13-05 CAMDEN, DE ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BERRY-SHORT FUNERAL HOME 21. Signature of Fineral Service Licensee MAIN ST., FELTON, DE 19943 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death letasta Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; After within 24 hours after death.
To the Funeral Diractor: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Thomicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) APR 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



APR 9,2005

SAlisburg Md. 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Naomi Elizabeth Martin 6:30 A. M 14 April 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mennonite Fellowship Home Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 25 1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 😿 F 216-80-1492 89 Penna Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Medical Examinating the resulting all 1 Yes 2 No Director MD. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12349 Huyett Lane 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel J. Diller Maggie S. Martin ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other treu <u>once</u>. Roger I. Martin/Son 117 South Valley Dr. Hagerstown, Md. 21740 Baltimore, 20b. Place of Disposition (Name of completely, crematory or other place)
Mt. Olive Mennonite Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/18/05 Maugansville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licenses · Marte 45 S. Carlisle St. Greencastle, Pa. 17225 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🔼 No 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitei 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 DO011266 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard N. Weeks, MD. 580 Northern Ave. Hagerstown, Md. 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Eleve & Spell Registrar APR 2 0 2005

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Dev **Physician** Year Dewey E. McCarty 10, 2005 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital & Medical Center Allegany Cumberland If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**⊠** M 2□ F Director 220-30-9115 70 Yrs. MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show out by rutilisd at 1X Yes 2 □ No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 South Street or items 23a 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other treumatic event, the Medical Examiner m 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene. Is marked other than "neturel", or iter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Marvland State Elementary/Secondary (0-12) College (1-4or 5+) 12 Associate Engineer Highway Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob E. McCarty Dessie L. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 sr Department of Health and Importent: if item 27 is n any injury or other treun 21511 National Pike N.E.Flintstone MD21530 Irene Bender/ Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 04/14/05 Rocky Gap Veterans Flintstone, MD 21 Signature of Fur eral Service Deeper 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RENAL FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE esn. 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ POLYCYTHEMIA VERA 1 ☐ Yes 2 YNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 🗌 Yes 2 X No 1 Tyes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2XNo 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 1 XNatural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after c Funerel Direc 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) within 2. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) D0033250 APRIL 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 DR. SUNIL GUPTA 625 KENT AVENUE SUITE 101 CUMBERLAND, MARYLAND 21502 State Registrar APR 2 0 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 21 2005 Ober HOO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Aberdeen 830 Hartord Maxa Kond If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Manths | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign Sountry) 5. Social Security Number **Funeral** 213-30-Yrs. Director 6 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-1 show any injury or other traumatic event, If a Modical Examination nation and some any injury or other traumatic event, If a Modical Examination nation is an once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Harton 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 830 2100 Load axa United Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1√Yes 2 □ No bYes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Year or Dates: KDi-Ca White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Gollege (1-4or 5+) Chaineerine tronic 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Majden Sumame) Be ames ナム ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 830 Maxa 1 lau 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 F
4 Donation 5 Other (Specify) 3 Removal from State ompany 21. Signature of Funeral Service Licenses 22. Name and Addres Facility HOME. FUNERAL Harring -Carco Hberdeen N 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MCER disease or condition resulting in death) COLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events nding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No been signed by the atter should be detached for u 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 2 No 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Tyes 2510 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death, investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D59858 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 611

Registrar

State

LOHNS

31. Date filed (Month, Day, Year)

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BOLTIMORE

MARKUND 21231

401 NERN BROSONAY

32. Figistrar's Signature

68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Eli E. Nobleman 10:00 P M 04 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1**∑**M 2□F Director 89 Yrs. 03/08/1916 108-03-1892 ŃJ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mental Hygbert. Importent: I file at 21s marked other then "neturel", or Items 23a or 28s-f ehow eny injury or other treumstic event, It a Medical Examinat must be notified at Director 1 Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5450 Whitley Park Terr Apt-301 20814 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 □ No WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lawyer United States Senate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman Nobleman Clara Fischer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Whitley Park Terr Apt-301 Bethesda, MD 20814 Elaine J. Nobleman - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gdns 04/05/2005 Olney, MD 21. Signature of Funeral Service Lipersee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Kertnic. tibni, anest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list on altitude, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 2**X** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 ankogue

Registrar

10

Tara M. Roque, MD 8600 Old Georgetown Rd Bethesda, MD 20819

329Registrar's Signature

30. Name and address of person who complet the e of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 855 Day Month **Physician** Year elen 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Grove Hoi, to If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7896 10M 201 219 36 97 Yrs. Director ,30,1908 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ust be notified at 1 Yes 2 No Completed by Funeral Director MONTGOMERY MD POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19825 FISHER AVE. 20837 USA itams 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and Teath and 27 is marked other than "natural", or Itams 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic evant, the Modical Exaculture. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION SCHOOL TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY LABON WILLARD DELMA DUDROW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM WILLARD/NEPHEW P.O. BOX 626, POOLESVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if its any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) MONOCACY CEMETERY 4/9/05 BEALLSVILLE, MD 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Tany, leading to in nediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 217No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ⊡ No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending within 24 hours after death.

To tha Funeral Diractor: A completely filled in by the fill 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Bev 1/2001

State Registrar Shall

32. Poistrar's Signature

Grave Advertit Hospital

Registrar

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ed cause of deeth (Item 23e) (Type, Print)

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Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physician: The law raquires that the death certificate be execu within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and complataly filled in by the funeral diractor, page 2 should be deteched for use as the burial-tra
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Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	State o	f Marylar			of Health an of Death	d Mental Hy	giene Reg. No. 2	005	121.0	
		1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath	<u> </u>	3. Time of Dea	
sician edica		ELIZABETH	ı.	SIM	MONS			MARCH	25. 20	005	9:50 P	
iminei		4a. Facility Name (If not institution,	give street and nu			4b. City, Tov	wn, or Location of D			unty of Death		
		MONTGOMERY VILLA	AGE HEALT	HCARE C	ENTER	MONTGO	OMERY VIL	LAGE	MO	ONTGOME	ERY	
eral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y Months D		Min (Month Da	v. Year)	9. Birth	place (State or For	
tor	- 1	234-30-7972	1□M 2□F	86	Yrs.	MIG. III.	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MAY 8,	1918	1918 WEST VIRGINIA		
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Director	960	MARYLAND MONTGO	MEKY		SAITHER	10f. Zip Co			10a Citiana	n of What Cou		
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200ce. To Re Completed by Financia Director To Re Completed by Financia Director	<u>~</u>	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.1					Race - Ameri		
	돌	1 ☐ Never Married 2 ☐ Marrie	Armed Fo	orces?				? (Specify Yes or No uerto Rican, etc.)		Black, White		
3	2	3 Widowed 4 □ Divorced	If Yes, Gir Year or D	ve ates:		1 ☐ Yes 2X☐	No Specify:		Sp	ecity: WH1	ITE	
, Pat	Completed	15. Decedent's			16a. Deced	dent's Usual O	ccupation	wadina	16b. Kind	of Business/Ir	ndustry	
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	0	JAMES	SARCO				PEAR	L "	UNKNOV	√N''		
		19a. Informant's Name/Relationshi						r Rural Route Numbe			p Code)	
	- 1-	EVA JUNE KAVOOKI	IAN, DAUG					., GAITHE			20878	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation :	3 X Removal from		Place of Dispo cemetery, crer	natory or other	of r place)	Date	20c. Locat	tion - City or T	own, State	
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ğ		21. Signature of Funeral Service Li	icensee/		DÃ	Name and A	ddress of Facility	G MEMORIA	I. CHAF	PELS. I	NC.	
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out use as the burial-training of the Madical Examiner	cal Examiner	shock, or heart failure List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ASPI Due to CORO Due to AZOT	RATION (or as a consec NARY AR (or as a consec	quence of): CTERY D quence of):						Interval Between	
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be deteched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live t	tcome of pregnation of the community of	al death 3	Ectopic pregn Other (specif			230	23d. Date of delivery Month Day Yea		
	Dy P	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying caus	e given in Part I.	23e. Did t	obacco use	contribute to I	the cause of death	
a patal		OSTEOPORO	SIS					_ 10'	/es 2∑∏N	lo 3□Pro	bably 4 □Unkn	
	Completed							24a. Was			opsy findings avail	
B 6	E							— autop perfo 1 Yes	rmed?	death?	ompletion of cause	
101	o l	25. Was case referred to medical					26. Place of	Death (Check only of	A	1 2 7 63	20110	
To B		examiner? 1 ☐ Yes 2 X No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA	Other	ng Home 5 Resi	_	Other (Speci	fy)	
g .		27. Manner of Death	28a. Date		28b. Time of Injury		Injury at Work?	28d. Describe				
	atic	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	ation		igary	М	1 ☐ Yes 2 ☐ No					
= 19	ا د	3 Suicide 6 Could no 4 Homicide determin	ned 286. Place	of Injury - At hing, etc. (Special	ome, farm, str fy)	eet, factory, of	fice	28f. Location (: City or Tox	Street and N vn, State)	lumber or Run	al Route Number,	
artifics	ertiti									stated.		
natasy lined in by the tunera		29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the b	asis of examina	ation and/or in	vestigation, in	my opinion, death t			ice, and due i	to the cause(s)	
platasy III	Medical Certifi	(Check only 2 Medical E	xaminer: On the b	asis of examina	ation and/or in		cense number			igned (Month,		
Modical Cariffic	edical	one) 2 Medical E	xaminer: On the b	asis of examina	ation and/or in		cense number		29d. Date s	igned (Month,	Day, Year)	
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			For State Registrar	State of	Maryland / De	partment of F ertificate of			giene 005	13482
		2.	1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month	ith Day Yea	3. Time of Death
	Physici /Medic	al	DOROTHY I.	SHELDON				April	2 200	
	Examin		4a. Facility Name (If not institution				or Location of Death	h	4c. County of D	
			Montgomery Ge			Olney If Under 1 Year	If Under 24 Hrs.	- 8. Date of Birth	Montgo	mery Birthplace (State or Foreign
	Funeral		5. Social Security Number 063.18.2473	6. Sex 7. 1 ☐ M 2 🖾 F	. Age (In yrs. last birthda 81 Yrs.	Months Days	Hours Min.		v, Year)	Country) New York
	Director		Usual Residence of Decedent		01			1107117	, 1723 03	
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1X Yes 2 ☐ No
	a-f el	ctor	Maryland Montg	gomery	Silver					
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w	ral	3707 Bethnal W			2090		Specify Ves or No-	U.S.A.	merican Indian,
	er de	Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☑ Mar	Armed Ford		Was Decedent of If Yes, specify Cub	pan, Mexican, Puer	to Rican, etc.)	Black, W	hite, etc.
36	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give		1☐ Yes 2☐ No	Specify:		Specify:	Wnite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 ehow the Medical Evaria are fundal ce rodified at	ted		nt's Education	16a. De	cedent's Usual Occupive kind of work done	pation during most of wo	rkina	16b. Kind of Busine	ss/Industry
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nd	be fill d oth even	Be	17. Father's Name (First, Middle,				Mabel	Beabout	Maloen Sumame,	
$\frac{2}{3}$	ould Men narke	은	Chester Park 19a. Informant's Name/Relations		19h M	ailing Address (Stree			er. City or Town, Stat	e, Zip Code)
Maryland	d2 st th and 7 is n traum		Ralph H. Shel							ring, MD 20906
e,	1 an Heal Iem 2		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla		Date	20c. Location - City	
non	A Paris of D		1 XBurial 2 Cremation 4 Donation 5 Other (tate	Memorial		06/2005	Olney, Mar	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow amy originary or other traumatic event, the Medical Expression and the rediffied at SORE.	11.3	21. Signature of Funeral Service			22. Name and Addr	ess of Facility	-		
ñ	Der Jany		Navey A	. Ke can	the	HINES-RINA 11800 New	ALDI FUNE Hampshir	ERAL HOME e Ave. S	ilver Spr	ing MD 20904
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that ca t only one cause on ea	used the death. Do not	enter the mode of dy	ing, such as cardia	c or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	W	40 cardial	2 Infa	uction			5 minute
П	/Medical		resulting in death)	Due to (c	or as a consequence of):					
Н	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequence of):					
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Вох	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy inth 2 Fetal death	3 Ectopic pregnance	су		23d. Date of Month	delivery Day Year
	deat he att	sicis	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		ant at time of death	5 Other (specify)				,
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Ta		e Co	25. Was case referred to medic		> Libus	٩	26. Place of De	1 ☐ Yes eath (Check only o	-1	165 20110
5	Physician: this certific	To Be	examiner?	Hospital:	npatient 2 ER/Outp	atient 3 DOA	ther: 4 Nursing	_		Specify)
of			27. Manner of Death	28a. Date o	of Injury 28b. Tin		ury at ork?	28d. Describe	how injury occurred	
ior	Attending Part death.	atio	Z L Accident	tigation			□Yes 2□No			
Division	I or Attendate death Director:	Certification:	3 Suicide 6 Could 4 Homicide deter	minod 289. Place	of Injury - At home, fam ng, etc. <i>(Specify)</i>	n, street, factory, office	9	28f. Location ((Street and Number o wn, State)	r Rural Route Number,
0	ital o irs afi ral Di					da a tha a san a sa tha a	time data and plac	an and due to the	course(s) and manns	er ac ctated
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1X Certify (Check only one) 1X Medica	ring Physician: To the al Examiner: On the ba and mann	best of my knowledge, of asis of examination and/	peath occurred at the or investigation, in my	opinion, death occ	ce, and due to trie curred at the time,	date and place, and	due to the cause(s)
	thin 2 the on the	Med	29b. Signature and title of certif		ier stated.	29c. Licer	nse number		29d. Date signed (A	fonth, Day, Year)
0	7) × 8	1			> W	0 6	43202		April 3,	2005
/	52		30. Name and address of person	n who completed caus	of death (Item 23a) (T	ype, Print) 3305	North 1	Leis one	world R	w
			C-Gzanne-	Blankfar	9 MD	Silve	e Sprin	y mar	yland 2	2080
		tate	31. Date filed (Month, Day, Yea		egistrar's Signature	Local :	•)		
	Regis	trar	ות מפת	a Zuuu <i>Feli</i>	Course III A	1				

			FOI	artment of Health and Me rtificate of Death		ene g. No. 2 11 11 5	12100	
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last) Irva Bernida Humes Savoy		2. Date of Death Month Iarch 31	Day Year	3. Time of Death) 0	
	Examin		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Silver Spring If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	4c. County of Death Montgomer	:y_	
	Funeral Director		579-18-6980 1□ M 2√ F 85 Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, July 10	Year) Coo.	nplace (State or Foreign untry) ashington, DC	
ore, Maryland 21215-0036	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Macinal Examination and once.	e Completed by Funeral Direc	1 Never Married 2 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 3 Married 4 Divorced 8 Married 9 Married	Spring 101. Zip Code 20903 Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puero Rich Yes, Specify: dent's Usual Occupation kind of work done during most of working DO NOT use retired) cator 18. Mother's Name (Agrace Des) ng Address (Street and Number or Rural In Its Green	ify Yes or No-ican, etc.) First, Middle, Midd	Specify: Black 16b. Kind of Business/Industry Public Schools Ile, Maiden Sumame) Age Aber, City or Town, State, Zip Code)		
Baltimore,	permit. Pages Department of I Important: If its any injury or o		14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licegsee		ire Fun			
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Division of Vital Records, P.	The law requires ate has been sign page 2 should be	e Completed by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. 26. Place of Death (1 Yes 24a. Was an autopsy perform 1 Yes 2	ed? 24b. Were aut prior to condeath?	the cause of death? bably 4 Munknown topsy findings available completion of cause of 2 No	
vision of VI	ttending Pl death. ctor: After ti y the funera	ertification; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide Hospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, st building, etc. (Specify)	ont 3 DOA Other: 4 Nursing Home of 28c. injury at Work? M 1 Yes 2 No	e 5 Residen	nce 6 Other (Spec vinjury occurred		
٥	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical Cert	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, an ivestigation, in my opinion, death occurred	id due to the cau	use(s) and manner as	stated. to the cause(s)	
•	To the I	Med	29b. Signature and title of certifier Dickward addy Ready MD 30. Name and address of person who completed cause of death (Item 23a) (Type,	29c. License number D43464 Print) E PINE, SUME 208,	Н	d. Date signed (Month	005	
	Sta Registi		VIKRAPADITYA D. REDDY, III X ROCKVILL 31. Date filed (Month, Day, Year) APR 0 5 2005 APR 0 5 2005		JOS OFFEE		-01	

		ı	1 - For State Registrar		Maryland / D	epartme Certifica			and M		Reg. No.	005	13481
	Physici /Media	cal	Decedent's Name (First, Middle Lois Marie Sh Aa. Facility Name (If not institution	elds	bar)	4h Cit	. Town o	Location o		2. Date of Dea Month April	5 Day	Year 2005	3. Time of Death
1	Examir Funeral	ier	Casey House 5. Social Security Number		. Age (In yrs. last birth	Rounday) If Und	kvil eriyear	1 e If Under 2	24 Hrs.	8. Date of Birt	Mont	gomer	
	Director		296-09-8149 Usual Residence of Decedent	1□M 2□ X F	86 Y	rs. Month	Days	Hours	Min.	July 3,	1918	Ohi	intry)
	Ith the Marylan or 28a-f show	Irector	10a. State 10b. County MD Montgo		10c. City, Town Silver	Spring	ip Code				10g. Citizen (of What Cou	10d. Inside City Limits 1 Yes 2 No ntry?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-1 show other traumatic event, the Madical Examiner must be notified at	d by Funeral Director	15115 Interlach 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deced Armed Ford	ent Ever in U.S.	13. Was Dec If Yes, sp	0906 edent of H edify Cuba 2 No	ispanic Orig in, Mexican Specify:	gin? (Spe , Puerto I	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White cify: Whit	, etc.
21215-0036	ad within 72 h giene. er then "nate i, the Medica	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	4or 5+)	Decedent's Us Give kind of v life. DO NOT Iomemak	ork done d use retired	ation during most ()	of workin	ng	16b. Kind of		ndustry
Maryland	12 should be filed within n and Mental Hygiene. 7 is marked other than "reaumatic event, the Mas	To Be (17. Father's Name (First, Middle, Cornelius Bow	man					Edit	(First, Middle,	r		
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m eny injury or other traum <u>once.</u>		James W. Shield 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S) 21. Signature of Fineral, Service	s / Husban	d 151 20b. Place of I cemetery Oak Hil	15 Int Disposition (N crematory of 1 Ceme	erlacente of other placente of the ry and Address	chen D)r. # /11/ Jose	507 Si late 2005 V eph Gaw NW Wash	lver S ₁ 20c. Locatio Vashing Ler's S	pring n City or T gton, Sons I	MD 20906 own, State
The second second	/Medical Examiner	Examiner	23a. Pent i Inter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury that initiated events resulting in death) Last	a. Metas Due to (o	used the death. Do not hine. tatic non- rasa consequence of rasa consequence of	small):	de of dyin	g, such as	cardiac o	r respiratory ar			Approximate Interval Between Onset and Death
ds, P.O. Box 68760,	es that the death certificate gned by the attending phy; be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome to the distribution of		3 □Ectopic 5 □ Other (pecify)	en in Part I.		3 Z			ery Day Year he cause of death? bably 4 □Unknown
Il Records,	The ate h page	Completed								24a. Was autop perfor	an 24l	b. Were auto	opsy findings available impletion of cause of 2 No
Division of Vital	Attending Physician: Thr death. octor: Atter this certificate by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could reference	28a. Date of (Month) ation of be	, <i>Day Year)</i> Inj	ne of ury M	28c. Injun Worl	er: 4 □ Nur	rsing Hon 2 No	28d. Describe h	ence 6X00 ow injury occ	urred	VHospice
Div	o fite		4 Homicide determ	building	of Injury - At home, farring, etc. (Specify) est of my knowledge,			ne, date and		City or Tow	n, State)		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical one) 29b. Signature and title of certifier	xaminer: On the bas and manne	is of examination and	or investigation	n, in my o	oinion, deat	h occurre	ed at the time, o	date and place 29d. Date sign	e, and due t	o the cause(s)
2-	(5)		30. Name and address of person	who completed cause	of death (Item 23a) (T	ype, Print)	04	121	8		4/0	5/0	5
	Sta	ate.	Charles Harriso 31. Date filed (Month, Day, Year)	n 6001 Mun	caster Mil	1 Rd R	ockvi	ille M	D	··			
	Regist	45	APR 0 7 2		w # A	me							

			State of Maryland / Department of Health and Certificate of Death		giene Reg. No. 🤈 🕦	05 10105
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month		Year (2000)
-	🤟 /Medio	al	4a Facility Name-(ff not institution, give street and number) 4b. City, Town, or	Location of Death	4c. County of	of Death
	Examir	er	The state of the s	msig	17	ward
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs 21.3 - 27 - 82.82 1 □ M 2対 F 75 Yrs. Months Days Hours Min	(Month, Da	h y, Year)	9. Birthplace (State or Foreign Country)
	Director		213-24-8282 / / 3 Yrs. Usual Residence of Decedent	Dec. 5,	1929	Maryland
	anylan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 11x Yes 2 □ No
	n the Maryla r 28a-1 sho	recto	Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code		10g. Citizen of W	
	h with	Funeral Director	8 Hill Street 21771		United	
	r deat	ner	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race Black	e - American Indian, k, White, etc.
)20	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show he Madical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify:	White
2-00	72 hours natural', dical Ex	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	rkina	16b. Kind of Bus	siness/Industry
121	within the the the the the the the the the the	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 10 (Give kind of work done during most of wo life. DO NOT use retired) Assembly Technician	•	Electr	oniac
d 2	Hygi Hygi Int, I	Be Co		me (First, Middle,	Maiden Sumame	
ylan	요 잘 잘 ㅎ	To B	Walter Reaver Deboral	n Boston		
Maryland 21215-0020	O 00 00		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Richard Number or Richard Name (Street and Number or Richard Nu			State, Zip Code)
	Heall Heall Jem 2		Diann Smith / Daughter 3003 Michael Rd. Mt. 20a. Method of Disposition (Name of cemetery, crematory or other place)	April 9,		City or Town, State
E S	Page anto t: ∺ yor		1 ∰Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Restahven Mem. Gardens	_	Frederic	k, Maryland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral			
_	70 E # 9		9501 Catcotin Mtn.	Hwy. Fr	ederick,	, MD 21701
	P hysician		23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory a	rest,	Approximate Interval Between Onset and Death
J. J.	/Medical		Immediate Cause (Final disease or condition resulting in death) Pava Thyroid (a)	rcer	7	6m0
	Examiner	_	resulting in death) Due to (or as a consequence of):			
	uted d ansit	Examiner	Sequentially list conditions. Due to (or as a consequence of):			
, 0	ficate be executed physician and is the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.			
68760,	icate be ex physician s the buria	edical	Cesse (crisease of injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Box 6	ath certific attending p for use as		d			
-	iaw requiras that tha death certi as been signed by the attending t.2 should be datached for use a	Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did 1	obacco use com	tribute to the cause of death?
P.0	hat tha od by th datach	Phy	hypercalcemia	10	Yes 2 No	3 Probably 4 Unknown
ds,	uiras ti signe	d by	- Jf Gr Gr Gr	24a. Was	an autopsy	24b. Were autopsy findings
ō S	s beer 2 shou	piete		perfo	med?	available prior to completion of cause of death?
E R	The ate h page	Com		101	res 2 No	1 ☐ Yes 2 ☐ No
Division of Vital Records,	ysician: The is certificate director, pag	Be	examiner?	ath (Check only o		
o	Phys arthis aral di	2	27. Menger of Deeth 28a. Date of Injury 28b. Time of 28c. Injury at	1	dence 6 □Othe now injury occurre	
sion	ending sath. or: Afte	atio	2 Accident investigation M 1 Yes 2 No			
Ξ	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Numbe vn, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place			
	the Ho iin 24 h the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			
6	Vit To Con	2	29b. Signature and title of certifier 29c. License number		_	(Month, Day, Year)
	(2)	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)		mpr E	, 2003
	9		Gary Kazlowmo 10805 Hickory Ridg	e Rd	Colum	Sig MA 2109
	Sta Registr	-	31. Date filed (Month Per Year) 7 200: 32. Rigistrar's Signature			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Beatrice Seifert 2005 April 4:20 A. /Medical 4a. Facility Name (If not institution, give street and number)
Snow Hill Nursing 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Snow Hill Rehabilitation Center Worcester 8. Date of Birth (Month, Day, Year) Sept 2, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 F 577-18-8658 91 Director West Virginia Usual Residence of Decedent with the Maryfand r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Wicomico Parsonsburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 31677 Hideway Drive 21849 death v Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 1 Never Married 2 Marned 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Secretary .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or othar traumatic evant, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willie S. Sanders Sylvia Maier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31677 Hideway Drive Parsonsburg, MD Richard A. Seifert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sanders Hill Cemetery Apr 9 2005 Tunnelton, WV 22. Name and Address of Facility Rotruck-Lobb Funeral Home 21. Signature of Funeral Service Licensee 295 South Price Street Kingwood, WV Part 1. Enter the disbase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. as the t IF FEMALE esn : 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ĺ Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 the detached ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 90 1 Yes 2 No 3 Probably 4 Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 219 No 2 4 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 00062172 04/05/2005 SHARAD ATTAL, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATTAL 1604 MARKET POCOMOKE SHARAD 31. Date filed (Month, Day 32. Pagistrar's Signature Year! State 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mar. 29, **Physician** 2 0°0 5 8:40а м Helen M. Stephens /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Oueen Annes Grasonville 625 Chester River Beach Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 62 Director 074-34-3261 Sep. 25, 1942 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-1 ehow other treumatic event, the Medical Examiner must be notified at MD Oueen Annes Grasonville 1 ☐ Yes 2X No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 625 Chester River Beach Road 21638 USA 238 Funeral death items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married ☐Yes 2 XNo Maryland 21215-0036 ŏ White 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker/Administrative Home/Army Corps permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien Importent: If Item 27 is marked other the any injury or other treumatic event the 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be August Bredley Helen Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 625 Chester River Beach Road, Grasonville, MD 21638 Dennis B. Stephens/Husband Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 29, Mar. 1

Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery Crownsville, MD 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Full eral Sovice Licenses Rarranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nter the disease, or com or heart failure. List only Onset and Death Inmediate Cause (Final disease or condition resulting in death) METASTAT **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Diseass or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed and -tran resulting in death) Last physician ar s the burial-ti Due to (or as a consequence of): Box 68760. Physician/Medical ası the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Day in the past 12 months? ō Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Xes 2 No Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 certificate 1 Yes Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only on Hospital: 1 | Inpatient examiner? Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify)
Injury at 28d. escribe how injury occurred 2 XN0 1 🗌 Yes 2 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of Certification: or Attending After 1 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours efter death To the Funerel Director: in by the 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on the 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License numbe U. N. me and address 31. Date filed (Month, Day, Year) State APR 04 2005 Registra

			1 - For State Registrar	State of	f Marylan		artmen rtificat			nd M	ental Hyg	iene200	5 13488
	Dhuoisi	-	1. Decedent's Name (First, Middle	Last)							2. Date of Deat Month	h Day Yea	3. Time of Death
	Physici /Medio		Edith	Virgin	nia	T	asker	•				8, 2005	12:10 A M
•	Examir	ner	4a. Facility Name (If not institution	give street and nun	nber)		4b. City,	Town, or	Location of	Death		4c. County of De	eath
7			132 Hillside						aklan			Ga	rrett
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. i	last birthday) Yrs.	Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	rear)	Birthplace (State or Foreign Country)
	Director		212-54-7802 Usual Residence of Decedent		54	115.					June 1,	1950 W	est Virginia
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Mary fish	jo	MD	Garrett				Oak	land				1 ☐ Yes Z∑ No
	128a	Director	10e. Street and Number	341252			10f. Zip				1	Og. Citizen of What	Country?
	deeth with the Maryland me 23a or 28a-f show roust be notified at	D	132 Hillside D	rive					21550			USA	
	deeti	Funeral	11. Marital Status		dent Ever in U.	S. 13.	Was Dece	dent of Hi	spanic Origi	in? (Spec	cify Yes or No- Rican, etc.)		merican Indian,
٥	after or Ite	Fu	1 ☐ Never Married 2X Marri		21 No		1 ⊡ Yes		n, mexican, Specify:	Puerto P	tican, etc.)	Black, Wi	
9500-61212	be filed within 72 hours after deeth with the Marylan tal Hygiene. d other than "natural", or Iteme 23a or 28a-f show event, I'ra Medical Examinar must be notilised at	d by	3 Widowed 4 Divorced	Year or Da	ates:		TLI TES	24 <u>5</u> 1 NO	эрөспу.			Specify:	White
ភ	72 h "natu	Completed	15. Decedent (Specify onfy highes	s Education t grade completed)		16a. Deced (Give	tent's Usua kind of wo	al Occupa	ation <i>furi</i> ng most ()	of workin	g	16b. Kind of Busines	ss/Industry
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	filed v Hygie other t		10th 17. Father's Name (First, Middle, I	act)				louse	wife	's Nama	(Circt Middle A	Hom	e
yland	ntal hed of	Be	Walter		Baker				Gert		(FIFST, MIGGIE, N	faiden Sumame)	Walters
	2 should be and Mental Is marked c	ပ္	19a. Informant's Name/Relationsh	in (Type Print)	Daker	10h Mailie	a Addross	/Stroot o			Pauta Mumbas	City or Town, State	
Mar	d 2 s th an t7 ls i		Donald B. Task		3							Md. 21550	, Zip Code)
	es 1 and 2 should b of Heelth and Ment fitem 27 is marked ir other traumatic e		20a. Method of Disposition	el/nusband	20b. P	lace of Dispo	sition /Nan	ne of				20c. Location - City	or Town. State
<u></u>	ages ant of it: If ii		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	emetery, crer				/12/			
baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service L		Joine	ga Cre		. //	s of Facility	/12/		Morgantow S. Secon	
ä	Dep Per Per Per Per Per Per Per Per Per Per		3 Lallen	/ wall A					neral			kland, Md	
			23a. Part1. Enter the disease, or	complications that ca	aused the death								Approximate
.	Physician		shock, or heart failure. List of Immediate Cause (Final			a 50 E	DOT	11.	0.4.4		. 1/0.00		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	140	10 (BILON	de	Juse	ular	gen
	Examiner		Soquestially list conditions	b					•	(16)	and the second		
-	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):							
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
Š,	oe ex cian g ourial	E	rosuming in south, East	Due to (or as a consequ	ience of):							
09/80	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial transit	dical		d									
×	ding se as	/Me	IF FEMALE:	23c. If yes, outo	come of pregnar	ncv						22d Date of d	
Ž Q	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Fetal ant at time of de	death 3	Ectopic pro					23d. Date of d Month	Day Year
į.	the c by the achec	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno	WN								
L	sician: The law requires that the death certific certificate has been signed by the attending precior, page 2 should be detached for use as	by P	Part II. Other significant condition	ns contributing to de	ath but not resu	Iting in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use contribute	to the cause of death?
Records	quire an sig uid b					· · · · · · · · · · · · · · · · · · ·				_	1 ☐ Ye	s 2□No 3□I	Probably 4 Ohknown
္ဌ	aw res	ompleted									24a. Was ar	24b. Were	autopsy findings available
	The I										autopsy perform	ed? L death?	completion of cause of
VII		BeC	25. Was case referred to medical				-		26. Place o	of Death	(Check only one		2010
	A S D	10	examiner? 1 Yes 2 No	Hospital:	patient 2 🗆 E	ER/Outpatien	t 3 DO	A Othe	r: 4 🗆 Nurs	sing Hom	e 5 Reside	nce 6 □Other (Sp	necify)
ō	ng Ph tter th neral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date o	f Injury h, Day Year)	28b. Time of Injury	2	8c. Injury Work	at ?	28	3d. Describe ho	w injury occurred	
Misjon	endl. eath. or: A	catl	2 ☐ Accident investig	ation			М		′es 2 □ No	0			
<u> </u>	or Att	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Flace	of Injury - At hor g, etc. (Specify	me, farm, stre	eet, factory	r, office		28	Bf. Location (Str. City or Town,		Rural Route Number,
ב	pital	O	29a. Certifier 1 ☐ Certifying	Physician: To the	host of my leasu	uladea daas		- A Ab - Ai					
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical		Physician: To the exeminer: On the ba and mann	sis of examinat	ion and/or inv	estigation,	in my op	e, date and inion, death	occurred	d at the time, da	te and place, and du	as stated. ue to the cause(s)
	To the within To the Comp	Ň	29b. Signature and title of certifier		0	0-	29c	. License			29	d. Date signed (Mor	
			Varl De	nDick	-	AD		Н2	6154			1/1/	105
			30. Name and address of person v										
			P. Daniel Mil. 31. Date filed (Month, Day, Year)		69 Wo.		es Dr	ive,	0akla	and,	Md. 21.	550	
	Sta Registr		0.00	2005	gional o olgital	As A	00						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year THOMAS NORMAN William 05 2004 06 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death White Church Stayer Rd bkland Garrett If Under 24 Hrs. 8. Date of Birth (Month, Dey. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months NAM 20 F 214-28-6713 73 Yrs Director 9-2-193 White Rock, MD Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Garrett Oakland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 35 White Church-Steyer Road 21550 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Affried Forces:

1 X Yes 2 No
If Yes, Give
Yeer or Dates: 1949-52 1 Never Married 2 Married Baitimore, Marviand 21215-0020 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Timberman permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
important; if tem 27 is marked other th
eny injury or other traumatic event, the Lumber 17. Father's Neme (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) James Thomas Minnie Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Doris Thomas/Wife 35 White Church-Steyer Rd., Oakland, Maryland 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sand Spring Cemetery April 10,2005 Friendsville, MD 21. Signature of Funeral Service Licenses 179 Miller St. Newman Funeral Homes, P.A. Dumai P.O. Box 275, Grantsville, Maryland 21536 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical tmmediate Cause (Final disease or condition resulting in death) a END STACE COPD Examiner Due to (or es e consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be assected within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnaria completely filled in by the funeral director, page 2 should be detached for use as the burnariance. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy TO Yes ZUNIO 1 ☐ Yes 2 ☐ No Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Fesidence 6 □Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Discribe how injury occurred Division 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer) 1+26154 completed cause of death (Item 23a) (Type, Print) Dr Ockland Mi) 21550 P.Daniel 69 Woh LAcres 31. Date filed (Month, Day 32. Pegistrer's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Harold Alton Travis 4, APRIL 2005 /Medical 15:20 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Min 1**X** M 2□ F Yrs. Director 80 215-20-5748 Sept 4 1924 Maryland Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinating must be notified at Director 1 X Yes 2 □ No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 385 Sunset Place 26726 permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23, any injury or other traumatic event, the Medical Examinat must once. Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ð 3 Widowed 4 Divorced Year or Dates: 1943-46 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) + Senior Advisor Auto Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John B. Travis Ethel C. Ravenscroft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard K. Barrick, III 329 "D" Street Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Apr 5 2005 Sunset Crematory Kingwood, WV 22. Name and Address of Facility Rotruck-Lobb Funeral Home 21. Signature of Funeral Service Licensee 295 South Price Street Kingwood, WV 26537 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocks or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. SEPTIC SHOCK 10 DAYS /Medical Due to (or as a consequence of): **Examiner** COLI URINARY TRACT INFECTION Sequentially list conditions, lary, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 DAYS Examiner Due to for as a nonsequence of): the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 1 Yes 2 XNo Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital or Attending Pl 4 hours after death. Funeral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar D25406

600 MEMORIAL AVENUE, CUMBERLAND, MD 21502

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APRIL 4, 2005

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMM, WILLIAM D., M.D., 600 MEMO

8 2005

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	Physic		1. Decedent's Name (First, Middle, Last			undato or		2. Date of De Month	Day	Year	3. Time of Death
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	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				1	Od. Inside City Limits
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	h the	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show any injury or other treumetic event. I'm Medical Exacilise must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		ce - Americ ck, White, y: Whi	etc.
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Maryland	nould be did Mental I marked o	To Be	Jesse Jessie Andrew Ba				Agne	es Virgin	ia Hend	ricks	
Ma	d 2 sho lth and 27 is ma treume		19a. Informant's Name/Relationship (T) Maureen E. Thorne/					Rural Route Numbe Edgewater			Code)
ē,	of Health of Health litem 27 I		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location -		wn, State
9	Pages nent of I int: If it		1 ☐ Burial 2 【Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		natory or other place rematory	·	-05	Edgewat	ter 1	Maryland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	00	22	. Name and Addre	ss of Facility	George P. and Rd. 1	Kalas 1	Funera	al Home
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Division	7 9 5 6	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
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			30. Name and address of person who co	mplefel cause of death	(Item 23a) (Type,	rint)	Anne	let m	2 did	Con	len
	Sta Registr		31. Date filed (Month, Day, Year) APR () 1	32. Registar's 9	Signature	South		1			

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	ysicia: Mediča	n	Decedent's Name	(First, Middle, L							2. Date of De	Rag. No. U	Year	3. Time o	
	amine	4a	i. Facility Name (If I PENINSULA	not institution, g. A REGION	ve street and number) AL MEDICAL	CENTER	-	4b. City, To SALI	wn, or Loca SBURY	ion of Death		4c. Coun	ty of Death	1 07+7	
Dire	eral ctor		Social Security Nu 228-19-24 sual Residence of I	439	Sex 7. Ag 1 1 M 2 □ F	36	rthday) Yrs.	If Under 1 Months D	ear If Un lays Hou	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da 03/27/	h y, Yea <i>r</i>) 69	9. Births	place (State ntry)	or Foreign
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ath with the 23a or 28	ustbenu	_	e. Street and Number 4379 Hori		ircle			10f. Zip Co	3395			10g. Citizen o	What Cour	ntry?	
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	eath with thes 23a or 24	erai Dire	RT. 1, BOX 328	3 12. Was Decedent Ever in U	S. 13. W	10f. Zip Code 26716	ispanic Origin?		USA 14. Race - An	nerican Indian,
920	ours after d irel', or Item Examiner	d by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	11	□ Yes 2 No	Specify:	(Specify Yes or No- erto Rican, etc.)	Specify: W	HITE
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel" or items 23a or 28e-f show importent: If item 27 is marked other then "naturel" or items 27 is marked other then "naturel" or 18 in 18	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) 4	(Give k	ent's Usual Occupi ind of work done of O NOT use retired HER	during most of v		16b. Kind of Busines	
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Baltimore,	permit. Pages Department of Importent: If it eny injury or o		1	MA	PLÉ SI	PRING	4-1 FUNERA	L HOME,	EGLON, W	V
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	To the Hospitel or A within 24 hours after To the Funerel Direction plate of the formal birection of the formal filled in the formal fi	Medical		ysician: To the best of my knowner: On the basis of examination and manner stated.						
	To the vithing To the comp	ž	29b. Signature and title of certifier	An100	« «l	29c. Licens	e number	-4	29d. Date signed (Mo	nth, Day, Year)
	4		30. Name and address of person who	completed cause of death (Ite	n 23a) (Type, F	Print)	A	e Mi	o Oali	and MM)
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 0 2	32. Filitar's Sign	ature A	neufi)	, ,,,,,,			150

			riease i	State of Ma					•		•	
			1 _ For Stete	State of Ma	iryland /				d Mental Hy	giene	005	10101
			Registrer			Cei	tificate of	Death		Reg. No	CUU.	13474
	Physic	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	/ Year	3. Time of Death
· >r	/Medi	cal	Robert Du		Vet	ra	# 02 T-		April	-	.005	10:30PM M
7	Exami	ner	4a. Facility Name (If not institution, give s				4b. City, Town, o		ath		County of Dea	
			34060 Five Bridge 5. Social Security Number 6. Sex		(In yrs. last b	irthday)	Prince If Under 1 Year	ss Anne	rs. 8. Date of Bir		omerset	
н	Funeral Director		1)2	M 2□F		Yrs.	Months Days	Hours M	in. (Month, Da	ıy, Year)		hplace (State or Foreign
			217-26-6171 Usual Residence of Decedent		84			1	05-15-	1920	mai	yland
	rylan		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Be-f.	cto	MD Somerset		Prin	cess	Anne					1 ☐ Yes 2 No
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	ountry?
	ath w	ra	34060 Five Bridge				218				USA	
	atems nare	Funeral	,	12. Was Decedent E Armed Forces?		13.	Was Decedent of H f Yes, specify Cubi	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	 Race - Ame Black, Whit 	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:			1□Yes 2 No	Specify:		j	Specify:	• .
Ö	be filed within 72 hours after death with the Maryland that Hygiene. od other than "netural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	ed	15. Decedent's Educ	cation	WWII 16	a. Dece	ient's Usual Occup	ation		16b, Ki	nd of Business	iite Industry
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5		(Give life. l	kind of work done DO NOT use retire	during most of v d)	vorking			,
21	giene giene er the	Completed	12	none	′′	P1	umber			P1u	mbing	
БП	be filed tal Hygie d other event, II	Be (17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle,	Maiden	Sumame)	
<u>yla</u>	should be and Mental s marked o umatic eve	일	Franklin Vetra					<u>_</u>	et Anders			
Maryland 21215-0036	2 sho and Is m		19a. Informant's Name/Relationship (Ty)						Rural Route Numbe			
6	as 1 and 2 should by Health and Ment ittem 27 is marked to other treumatic e		Terry Bozman/Daug	nter				res Dri	ve, Princ			
Baltimore,			20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	cemet	ery, cren	sition (Name of natory or other plac	·	Date		cation - City or	
Ħ	permit. Pag Department Important: I any injury o		'4 □Donation 5 □ Other (Specify)		Beech		Cemeter		/09/2005	Prin	cess An	ne, MD
Ba	Depa Depa Impo any ii		1. Signature of Funer VS price License	Maria		Hi	. Name and Addre nman Fun	eral Ho				
			33a. Part1. Enter the disease, or compli	cations that caused	00295	11	673 Some:	cset Ave	e., Princ	ess	Anne, M	D 21853 Approximate
			shock, or heart failure. List only on Immediate Cause (Final	ne cause on each lin	e.	, mot onto	or the mode of dyn	ig, such as card	ac or respiratory a	irest,		Interval Between Onset and Death
7	Physician /Medical	0	disease or condition resulting in death)	a	45C							
	Examiner			Due to (or as a		,	INSU N					
	_	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a								
	te be executed ysician and ne burial-transit	Examiner	that initiated eventsc									
oʻ	an ar	EX	resulting in death) Last	Due to (or as a	consequence	e of):						
3760,	ate be hysici	cal	U d	1								
89 ×	leath certificate attending phy I for use as the	Med	IF FEMALE:									
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 🗆 Fetal deat		Ectopic pregnancy	,		2	23d. Date of deli Month	very Day Year
o.	the a	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death	5 ∟	Other (specify) _	-				Day (32)
Δ.	that the		Part II. Other significant conditions con	tributing to death bu	t not resulting	in the ur	iderlying cause giv	en in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?
Vital Records,	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	d by							1 🗆 1	res 2[□No 3□Pro	obably 4 Junknown
00	w require been si should b	lete							24a. Was	an	24h Were au	topsy findings available
Re	The larate has	ompleted							autop perfo	rmed3	prior to death?	completion of cause of
tal		O	25. Was case referred to medical					26 Place of D	1 □ Yes eath <i>Check onl</i> o		1 L Yes	2□ No
Ž	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No	lospital: 1 🗆 Inpatier	nt 2 ER/C	utpatien	t 3 DOA Oth		Home 5 Resid		Other (Spec	eifv)
n of	ding Ph th. After th funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injur	y at	28d. Describe h			
Sio	Attending r death. ector: After by the funer	catl	2 Accident investigation					Yes 2 □No				
Division	or Attencater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry - At home, t . <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location (5 City or Tox	Street and vn, State,	d Number or Ru	ral Route Number,
	hours a uneral D	ဦ	200 Continue of Continue Division	1					1			
		edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ner: On the basis of and manner stat	examination a	je, death nd/or inv	occurred at the tin estigation, in my o	ne, date and pla pi <i>n</i> ion, death oc	ce, and due to the c curred at the time, o	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	and marinor star			29c. Licens	e number		29d. Date	a signed (Month	n, Day, Year)
	F S F O		Num				04	17094	,		4/8/0	5
			30. Name and address of person who con	mpleted cause of de	ath (Item 23a)	(Type, I		1 9			1101	
			Vel Nateson, M.I	•			· ·	eet, Sa	lisbury,	MD 2	1804	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						· · · · · · · · · · · · · · · · · · ·	
	Registi	ar	APR 112	005	we b	1	bode					

		1 - For State of Registrar		artment of Health and N	•	0000 10100
Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Mary Jane Voorhees 4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Death 6:00 p 4c. County of Death
Funeral Director		386–12–1572 ^{1□ M 2} ▼F	7. Age (In yrs. last birthday) 78 Yrs.	Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Sep. 6,	9. Birthplace (State or Foreign Country) MI
e Maryland 8a-f show Ilfied at	ctor	Usual Residence of Decedent 10a. State	10c. City, Town or Lo	Arnold		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Jeath with the	Funeral Director		dent Ever in U.S. 13.	10f. Zip Code 21012 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		Citizen of What Country? USA 14. Race - American Indian,
within 72 hours after death with the Maryland one. than 'natural', or Itams 23a or 28a-f show tam death and the natified at	þ	Armed For 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Giv Year or Da 1 ☐ Widowed 4 ☑ Divorced Year or Da 15. Decedent's Education	2 X No e ates:	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2X No Specify: dent's Usual Occupation		Black, White, etc. Specify: White b. Kind of Business/Industry
D 0 2	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+) (Give	kind of work done during most of work DO NOT use retired) Homemaker	ing	Home
\$ <u>a</u> <u>a</u> <u>b</u>	To Be	17. Father's Name (First, Middle, Last) Furman Balsinger 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir		e (First, Middle, Ma Ortright al Route Number, C	
Pages 1 arent of Heamut: If item		Terrance Materniak/Son 20a. Method of Disposition 1 Burial 2 Cermation 3 Removal from S 4 Donation 5 Other (Specify)	20b. Place of Dispo	matory or other place) Apr.	Date 20	c. Location - City or Town, State Baltimore, MD
permit. Par Departmen Importent: any Injury once.		21. Signature of Funeral Service Licenseer 23a. Pari 1. Enter the disease, or complications that creshook, or heart failure. List only one cause on expenses.	aused the death. Do not ent	er the mode of dying, such as cardiac	vy, Severi or respiratory arrest	na Park Funeral Home na Park, MD 21146 Approximate Interval Between Onset and Death
death certificate be executed death certificate be executed e attending physician and id for use as the burial-transit	ilcai Examiner	Sequentially list conditions, and the sequentially list conditions, and the sequentially list conditions, and the sequential list conditions, and the sequential list conditions are sequentially list conditions. Due to (sequentially list conditions, and sequentially list conditions are sequentially list conditions.	or as a consequence of): or as a consequence of): or as a consequence of):	ular acc		0.093
at the death certifically the attending ptrached for use as the	Physician/Med	in the past 12 more sea	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
2 2 2	by	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
The ate h	e Completed	25. Was case referred to medical		26 Place of Deat	24a. Was an autopsy performer 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
anding Phy lath. or: After this	ertification; To B	examiner? 1 Yes 25 No Hospital: 1 let 27. Manner Peath 1 Natural 5 Pending investigation 28a. Date (Montal)	patient 2 ER/Outpatier of Injury h, Day Year) 28b. Time of Injury	nt 3 OOA Other: 4 Nursing Ho		e 6 Other (Specify) injury occurred
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely titled in by the fune fune.	0	4 Homicide detailmined buildin	of Injury - At home, farm, str ng, etc. (Specily)		City or Town, S	
To the Hos within 4 ho To the Func completely t	Medical	(Check only one) 2 Medical Examiner: On the based manner: 29b. Signature and title of certifier	isis of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occur	red at the time, date	se(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
C > F 0		30. Name and address of person who completed caus	e of death (Item 23a) (Type,	MD 05072 Print) 1	5	4-1-2005
Sta Registi		31. Date filed (Month, Day, Year) APR 0 4 2005	8601 Veta	erans Huy No	Versi	. le MD 21108

			For State Registrar	S	tate of Ma	ryland	/ Depa	rtment of F	lealth and <i>Death</i>	Mental Hy	giene Reg. No.	2005	13496
	0		Decedent's Name (First, Midd.	e, Last)						2. Date of De.		Vaar	3. Time of Death
	Physicia /Medic		Stanley	<u>L.</u>		Var	nMete	•	Sr.	04	14	05	12127PM
~	Examin	er	4a. Facility Name (If not institution	4	HOSP	ital		Cum	Location of Dea	nd	1	County of Deat	any
	Funeral Director		5. Social Security Number 216-22-5806	6. Sex 1√2 M	2□ F 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h y, Ygar) 102	9. Bips	nplace (State or Foreign Unity)
			Usual Residence of Decedent							1404 12	, 192		IVID
	nylan show		10a. State 10b. County			-	Town or Lor						10d. Inside City Limits
	ne Ma 8a-f s	cto		gany			Rawlii						1 ☐ Yes ⅔ ☐ No
	with the	Funeral Director	10e. Street and Number					10f. Zip Code	21557		10g. Citiz	en of What Co	untry?
	eath	erai	P.O. Box 242	12.	Was Decedent E	ver in U.S.	. 13. V			Specify Yes or No	- 1	4. Race - Ame	ncan Indian.
36	2 should be liled within 72 hours after death with the Maryland and Menhall Hygiene. Is marked other then "netural", or Items 23s or 28s-f show eumstic event, the Medical Examinating the notified at	by Fun	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried	Armed Forces? 1. ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0		Yes, specify Cub ☐ Yes 2 No	an, Mexican, Puè Specify:	Specify Yes or No irto Rican, etc.)		Black, White Specify: whi	e, etc.
Ö	2 hou	ted	15. Deceder	it's Education	on		16a. Deced	ent's Usual Occup	pation	orkina		d of Business/l	
215	thin 7 e.	Completed	(Specify only higher Elementary/Secondary (0-12)		<i>mpietea)</i> College (1-4or 5-	+)		kind of work done OO NOT use retire					
2	ed wi ygien ner th		12	()		c	onstru	iction woi			Loca		
/land	0 = 0 5	To Be	17. Father's Name (First, Middle, Melvin VanM							ame (First, Middle, Sadie Van			en
	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evonce.		19a. Informant's Name/Relations Goldie VanMete		Print) wife			Box 242	and Number or F	Rural Route Numbe Rawli			(ip Code) D 21502
ore	ot He ot He fiterr	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □ Bem/	oval from State	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other place	ce)	Date	20c. Loc	ation - City or	Town, State
Ĕ	Pages ment of lent: If it		`4 □Donation 5 □Other (S	Specify)	OVER IT OHIT CLEED	Bierto	own Ce			4/18/2005	Rav	vlings	MD
Ball	permit. Departr Imports any inj		21. Signature of Funeral Service	Licensee	12/1	M	1 22	Name and Addre Scarpell 108 Viro		Home, PA ue: Cumber	land, I	MD 21502	2
V	Physician and physician and physician the price in a pr	Examiner	23a. Rank Enter the disease, o shock, or heart failure. Lis Immediate Chuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b c	Due to (or as a	e. Add conseque	ence of):	or the mode of dyir		ac or respiratory au	rest,		Approximate Integral Between Onset and Death Onset and Death
P.O. Box 68760,	t the death certificaby the attending parched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		If yes, outcome of 1 □ Live birth 24 □ Pregnant at 19 □ Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)	/		2:	3d. Date of deli Month	very Day Year
ds, F	ires tha signed d be del	by	Part II. Other significent condition	ons contrib	chile I	not resulti	ing in the ur	derlying cause giv	en in Part I.	23e. Did to		1	the cause of death?
al Records,	ician: The law require certificate has been sig rector, page 2 should b	Completed	Glionic Diabites	res	ial F	all	leve			1 Tes	med! 2 No	prior to death?	topsy findings available completion of cause of
Vita	yeician: is certific director,	To Be	25. Was case referred to medical examiner?	Hosp	oital: 1 Inpatier	nt 2∏Ef	R/Outpatien:	3 DOA Oth	00	eath (Check only only only only only only only only		Other (Spec	eifv)
of	g Phy er this ieral c	T:U	27. Manner of Zeath		28a. Date of Injury (Month, Day	y 2	8b. Time of	28c. Injur Wor	THE RESERVE TO THE RE	28d. Describe t			
ion	ath. r: Att	atio	E / (OO) GOT II	gation	(Month, Day	1601/	Injury		Yes 2 □No				
Division of	al or Atte s after de il Directo id in by th	Certification:	3 Suicide 6 Could 4 Homicide deterr		28e. Place of Inju building, etc	ry - At hom . (Specify)	e, farm, stre	eet, factory, office		28f. Location (5 City or Tox	Street and vn, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: Alter this certifica completely tilled in by the funeral director; p	edicai C	29a. Certifier (Check only one) Certifyi Medical	ng Physicie Exeminer:	en: To the best of On the basis of and manner state	examinatio	edge, death on and/or inv	occurred at the tirestigation, in my o	me, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certific	D . 1	26	M.	The	29c. Licens	e number	> >	29d. Date	signed (Month	n, Day, Year)
7	6		30. Name and address of person	who compl	leted gause of de	athy(Nem 2	23a) (Type, I	Print) / A	10000		77	15/05	
	2		<u> 70</u>	0 1	etm	1000	·	imbella	ic 10	14 01)	01		
3 2	Sta Registr		31. Date filed (Month, Day, Year APR 2		32. Pagistra	rs Signatui	re * A	ack!					

1	•		1- For State of Maryland / Dep	artment of Health and I		ene	10107		
			Decedent's Name (First, Middle, Last)		2. Date of Death	the tol and the	3. Time of Death		
	Physici /Media		MAC WALL		Month	Day Year	6:45 M		
7	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Dea	th		
			NORTHWEST HOSPITAL UT	RANDALLSTOW	1		MORE		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day)	(ear) 9. Bir	thplace (State or Foreign ountry) th Carolina		
	Director		216-12-0732 180 Yrs. Usual Residence of Decedent		1/28/23	Nor	th' Carolina		
	land		10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits		
	Mary	ō					TXXYes 2 □ No		
	28a	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	ountry?		
	3a o			21001		U.S.A.			
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	erican Indian,		
9	after or Ite	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No	Tries, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whit	e, etc.		
ဋ	hours after death with the Maryland turel', or items 23a or 28a-f show al Exercinar must be notified at	d by	3 № Wildowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: Wi	nite		
5	72 h	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work	king 16	b. Kind of Business	Industry		
12	within ne. han	ם	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		~ .	/2		
2	Hygie Hygie ther t		8 0 SELI 17. Father's Name (First, Middle, Last)	employed		Carpenter,	building		
Maryland 21215-0036	ontai ed o	Be c	Robert Wall		ne (First, Middle, Ma	,			
<u> </u>	shoul nd Me mark	2		ng Address (Street and Number or Ru	earl Wagne		Zio Codal		
	nd 2 Ilth a 27 is r trau				erdeen, M		21001		
ē,	s 1 a if Hea item othe		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or			
altimore,	Page nent c int: if		Sporiar 2 Defendation 3 Definition State	e Cemetery 4/23	/05 Be	el Air, Ma	arvland		
aĦ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any foliury or other traumatic event, it is Medical Evantment must be notified at once.						7		
<u>m</u>	89789		Wish A Malis Del A	^{2. Name and Address of Facility} arring—Cargo Fune: berdeen, Maryland	ral Home, 21001-31	P.A. 399			
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between		
diag	Physician		Immediate Cause (Final disease or condition	PNEUMONIA	+		Onset and Death		
	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	SMENTA					
	led Isit	nlne	The state of the s	un ACOINEA	100				
	al-trar	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. CEREBROVAS CUL Due to (or as a consequence of):	ALL ALLIPEN	7/3				
8760,	cate be executed physician and the burial-transit	dical E							
89	ificate g phy as the	edlo	0.						
Вох	n cert andin use a	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	verv		
m.	death e atte	lcla	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year		
P.O.	that the death certified by the attending of detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown						
Ś	8 8 9	þ	Part II. Other significant conditions contributing to death but not resulting in the unlike the part of the part o	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?		
ord	w requir been si should I	ted	LEIVEC FAILURD		1 🗆 Yes	2 No 3 Pro	obably 4 Unknown		
ပို	has by	nple			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of		
<u>~</u>	cate ?	Completed			performe	d? death?	2 No		
Division of Vital Records,	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? Hospital: *** Processing the second of the		h (Check only dne)				
ot	Phys this rat dir	-T	TEMpatient 2 ER/Outpatien			e 6 Other (Spec	ify)		
o	tending Physication: After this the funeral di	tlon	1 Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred			
<u>S</u>	or Attendate after death. Director: A	fica	3 Suicide 6 Could not be		28f Location (Street	t and Number or Ru	ral Pouts Number		
2	afor, after	Certification:	4 Homicide determined 289. Place of injury - Arthorne, farm, sm	oot, tastory, onlog	City or Town, S	itate)	rai moute muniper,		
	ospit hours unera y fille		29a. Certifier 10 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place,	and due to the caus	e(s) and manner as	stated.		
	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	(Check only 2 Medical Examiner: On the basis of examination and/or invariant and manner stated.	vestigation, in my opinion, death occur.	red at the time, date	and place, and due	to the cause(s)		
	To T	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month			
7			1 Value MD	D53910	4	FR 17	,2005		
,	つて		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1				
	Sta	•	31. Date filed (Month, Day, Year) 32. Ranistrar's Signature	TIVSTITAL, FAT	VDALL570	WW, IND			
	Registra		A MAHESHWARI MD, WORTHWAST 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 0 2005	Certa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State RegistravenD#29dperMD4/5/05, EMW, McCo Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2:55PM **Physician** Zics Rose K. Williams /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 01ney Montgomery Montgomery General Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. 1 M 2 F Months Days Hours Yrs. Director 82 Aug 18, 1922 Indiana <u> 308–18–7767</u> Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow miportant: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Marical Experiment or met be notified at once. 1 ☐ Yes 2 ☐XNo Director **Rockville** Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20853 #312 USA 14639 Bauer Dr, Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Baltimore, Maryland 21215-0036 ρ 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 NASA Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tillie Tisman Henry Korb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1509 Crestline Rd, Silver Spring, MD 20904 Charlotte Stone/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery | Apr 3, 2005 | Adelphi, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee Jamos U 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only enactause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oceup **Physician** disease or condition resulting in death) /Medical a conse uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executad attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) by the a ☐Yes 2 ☑No 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? signad b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Social Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate fo the Hospital or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA 2 this Diractor: After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, 29b. Signature and title of certified

12

MHClay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ILKIN

9210 Corporite SING Rocky 1/le

4-1-2005

State Registrar MICHAGZ

31. Date filed (Month, Day, Year) PREME

D.

			1 - For State Registrar	State of M	Maryland		artment rtificate			and M		giene Reg. No	2005	131	99
	Physici	an	1. Decedent's Name (First, Middle, L	ast)			h	JA	TT		2. Date of De Month April	Da		3. Time o	
	/Medio Examin		4a. Facility Name (If not institution, gi	ve street and numbe	mber) 4b. City, Tow				Location o		Whill		. County of Deal	6:05	A
	LAGIIIII		5140 Newport Ave	·			Bethe	sda				N	Montgome	rv	
	Funeral		5. Social Security Number 5.79-50-31.79 6.	Sex 7.7	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months [If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/26/	rth	9. Birt	hplace (State	or Foreign
l.	Director		Usual Residence of Decedent		113.						12/26/	hingto	n, DC		
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show lical Examination must be mailfied at	ctor	10a. State 10b. County Montgon	nery		, Town or Lo nesda	cation							10d. Inside 0	City Limits s 2 ☐ No
	or 28	Dire	10e. Street and Number				10f. Zip C					10g. Ci	tizen of What Co	ountry?	
	s 23a	eral	5140 Newport Ave.	12. Was Decede	nt Ever in 115	S 13 1	2081		enanic Orio	nin? (Sne	USA	14. Race - Ame	nican Indian		
920	urs after d al', or Item Examiner	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 23 If Yes, Give Year or Date:	s? ☑No	1	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:						Black, White	e, etc.	
21215-0036	d within 72 hours after death with the Marylan jene. I than "natural", or Items 23a or 28e-1 show It a Marical Examiner must be notified at	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed)	or 5+)	(Give life. I	dent's Usual 6 kind of work DO NOT use	done di	urina most	t of workir	ng		Kind of Business	Industry	
d 2	filed v I Hygie other t		17. Father's Name (First, Middle, Las	t) Z		Manag	er		18. Mothe	r's Name	(First, Middle		Sumame)		
an	should be nd Mental marked o	To Be	Frank M. Watt, Sr						Alic	e A1	burger		,		
Maryland		-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (S	Street a					or Town, State, 2	Zip Code)	
Σ,	is 1 and 2 of Health a Item 27 is other trai		Gail Smith / Wife								esda,				
Baltimore,			20a. Method of Disposition 1 Burial Cremation 3				sition (Name natory or othe				ate		ocation - City or		
Itim	그 문문을 .		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Mt.	Comfo	rt Cre	mate Address	ory A	Aprii	6,05	Ale	xandria	VA.	
Ba	permi Depa Impo any Ir	5130 Wisconsin Ave. N.W., Washingt													016
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caus	sed the death								8	Approxima Interval Be	ate etween
	Prrysician		Immediate Cause (Final disease or condition	. EMP	'HYSI	ENA								Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ience of):									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or injury	b. Due to (or as a consequence of):											
	cuted nd ransit	Examine	triat initiated events	c											
30,	oe exe cian a		resulting in death) Last	Due to (or a	as a consequ	ience of):									
8760,	icate be executed physician and s the burial-transit	dicai		d											
.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	Ectopic preg Other (spec						23d. Date of dea	ivery Day	Year
Vital Records, P	ires tha signed d be de	۵	Part II. Other significant conditions	Contributing to death	but not resu	ılting in the u	nderlying cau	ise give	n in Part I.			tobacco Yes 2	use contribute to	_	death? Unknown
eco	e law requ has been je 2 shoul	Completed									24a. Was	psy		topsy findings completion of	available cause of
R	(0) L.L.	Con									perfo 1 ☐ Yes	2 No	death?	2□ No	
Vita	Physicien: This certificates all director, p.	o Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only		- Cou		
ō		\vdash	1 Yes 2 No 27. Manner of Death	1 □ Inpa 28a. Date of Ir	njury	ER/Outpatien 28b. Time of		: Injury Work	4 🗆 140	rsing Hon 2	ne 5 Hesi 8d. Describe		6 Other (Spenry occurred	city)	_
ion	ttending I death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigate	on	Day Year)	Injury	М		es 2 🗆 !	No					
Division	l or Attend after death Director: I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, o	office		2	8f. Location (City or To		nd Number or Ru e)	ıral Route Nui	mber,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier 1 Certifying P	hysicien: To the be miner: On the basis and manner	of examinat	wledge, death ion and/or in	n occurred at vestigation, in	the time	e, date and inion, deal	d place, a	ind due to the ed at the time,	cause(s date an	and manner as d place, and due	stated. to the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and itle of certifier				29c. l	icense	number			29d. Da	e signed (Mont	h, Day, Year)	
) (KIW	Ms				D:	265	71		4	11/05	-	
P	(10)		30. Name and address of person who	completed cause of	010	215	FEW	WÜ	NO P	D	BETH	ESI	PAIME	208	17
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 7 200	Feet Regi	strar's Signat	Soci									

			1 - For State Registrar	State of Mar		artmen rtificate			nd Mental F	lygien Reg. N	2005	3500
н	Physic	ian	Decedent's Name (First, Middle, Last,)					2. Date of Month		ay Year	3. Time of Death
	/Medi			1sh					April	6,	2005	5:55 A M
	Exami	ner	4a. Facility Name (If not institution, give	street and number)				Location of E	Death		tc. County of Death	
			Casey House 5. Social Security Number 6. Sec	7 400 (In yrs. last birthday)	Rock If Under		e If Under 24	Hrs. I o Data of		ontgomery	
	Funeral Director			M 2XF	91 Yrs.		Days		Min. (Month,	Day, Yea	1913 Mary	place (State or Foreign intry) 11 and
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show fra Madical Exporter must be notified at		10a. State 10b. County	1	Oc. City, Town or Lo	cation						10d. Inside City Limits
	8e-fs	Funeral Director	Maryland Montgome	ry	Chevy Cha	se						1 ☐ Yes 2 🕅 No
	ith th	Dire	10e. Street and Number			10f. Zip	Code			10g. C	Citizen of What Cou	ntry?
	s 23a	rai	8100 Connecticut A			208				USA		
	Item	-un-	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No 	er in U.S. 13.	Was Decedor f Yes, spec	ent of His ify Cuban	panic Origin , Mexican, P	? (Specify Yes or Juerto Rican, etc.)	No-	14. Race - Americ Black, White,	
336	urs af	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No No	Specify:			Specify:	
Õ	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usua	I Occupat	ion		16b.	Kind of Business/In	lite
21	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	NOT us	k done du e retired)	iring most of	working			
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gue	12 should be filed within "n and Mental Hygiene." I's marked other then "reumatic avant, I're Mag	Be	17. Father's Name (First, Middle, Last)						Name (First, Midd		en Surname)	
7	d Mer d Mer narke	ဥ	Charles H. Berry	0.1.1					es Rober			
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, item 27 is marked other then "natural", or Items 23a or 28e-1 show other traumatic avent, the Medical Experiment must be notified at		19a. Informant's Name/Relationship (Ty) Thomas Hammond Wel								or Town, State, Zip) Code)
	Heal Heal tem 2	1	20a. Method of Disposition		20b. Place of Dispo	sition (Nam	e of		dlersvil	-	MD 21668 Location - City or To	oum State
Baltimore,	permit. Pages 1 and 2 Department of Health i Important: If item 27 i any injury or other tre <u>once</u> .		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cemetery, cren	natory or oti	her place)		pril 7,			
Ħ	permit. P Departme Importan any injur	1	21. Signature of Funeral Service-License		W. Arunde				2005		nton, Mar	
ñ	Depar Impor any ir		Blualy L. H	and the	Go:	ing Ho	ome (Teckro	ion Serv	ice	P.O. Box	784 MD 21029
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	death. Do not ente	er the mode	of dying,	such as car	diac or respiratory	arrest,	arksville	Approximate
	Physician		Immediate Cause (Final	Metastatio	colon C	ancor						Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co		ancer						
	LAdillilei	_	Sequentially list conditions, b									
	ted :	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classe of injury that initiate assets)	Due to (or as a co	onsequence of):							
	al-trar	xan	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	dicai E	d		, ,							
68	tificat ig phy as the	ledic										
Вох	eath certific attending p	Physician/Me	200. Was decedent pregnant	3c. If yes, outcome of p		Catania ara					23d. Date of delive	ery
). E	ed fo	sicis	in the past 12 months? 1 ☐ Yes 2 X No	4☐Pregnant at time		Ectopic pre Other (spe	gnancy cify)				Month	Day Year
P.0	that the de ed by the detached	Phy	9 □ Unknown									
ŝ	es pe	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the un	derlying car	use given	in Part I.			use contribute to th	e cause of death?
oro	w requir been s	eted							- 1	Yes 2	No 3 ☐ Prob	ably 4 Unknown
Records,	2 2 2	Completed							24a. Wa	opsy	prior to con	psy findings available mpletion of cause of
_	n: The licate har, r, page					_			1 🗆 Yes	formed?	death?	2□ No
Vital	Physicien: 7 this certificat al director, p	o Be	25. Was case referred to medical examiner?	ospital:			Othor		Death (Check only			
	y Phys or this oral di	\vdash	1 Yes 2 XNo 27. Manner of Death	28a. Date of Injury	2 ER/Outpatient		c. Injury at		g Home 5 Res		6 Other (Specify	hospice
<u>io</u>	Attanding r death. sctor; After yy the fune	atio	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	M	Work?	s 2 No			,	
	al or Attand after death Director; A d in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury -	At home, farm, stre	et, factory,	office		28f. Location	(Street ar	nd Number or Rural	I Route Number,
Ö	tal or	Cert	4 Tribilities	building, etc. (S	рөспу)				City or To	own, State	9)	
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only ane)	cian: To the best of more: On the basis of exa	y knowledge, death amination and/or inve	occurred at estigation, in	the time, n my opin	date and pla ion, death or	ace, and due to the ccurred at the time	e cause(s , date and	e) and manner as sta d place, and due to	ated. the cause(s)
	To the I within 2 To the I complet		29b. Signature and title of dertifier			29c.	License n	umber		29d. Da	ite signed (Month, L	Day, Year)
•) KA			D35	635			Apr	il 6, 200)5
a	_		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type, P						0, 200	
			Joseph Kaplan M.D.			Road	Roc	kville	e, MD 208	55		
	Sta Registra	te ar	31. Date filed (Month, Pay Year) 7 20	32. Registrar's S	Signature	ne ste	,					